Original

Hamilton County Hospital Authority d/b/a Erlanger Medical Center

CN1409-038

erlanger

RECEIVED
SEP 13 2013

September 11, 2013

Ms. Melanie M. Hill
Executive Director
State of Tennessee
Health Services & Development Agency
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, TN 37243

RE: 3T MRI CON Application
Chattanooga- Hamilton County Hospital Authority d//b/a Erlanger Medical Center

Dear Ms. Hill;

Enclosed is our CON application and filing fee for the purchase of a 3T MRI to be located at Erlanger Medical Center. In accordance with 0720-10-.05, the Chattanooga Hamilton County Hospital Authority respectfully requests that the application be placed on the Consent Calendar so we may expedite implementation of the project. We believe it is appropriate to place this CON on the Consent Calendar for the following reasons:

- Erlanger Medical Center is an existing provider of MRI services and is exempt from MRI specific CON review criteria. As a result, it unlikely that the application will be opposed.
- Utilization levels of the 3 existing MRI units at Erlanger Medical exceed optimal capacity by 34% and maximum capacity by 7%. Erlanger has extended shifts and hours of operation to accommodate utilization and is still unable to meet needs.
- Utilization of MRI services at Erlanger exceeds all other hospital and outpatient providers in the region and is more than double the average of all providers combined.
- Erlanger Medical Center is the region's safety net provider and qualifies for special consideration; it is important that all patients have access to 3T MRI services regardless of their ability to pay. Special consideration is also warranted as the 3T MRI will be utilized by pediatric patients; Children's Hospital at Erlanger is physically integrated into Erlanger Medical Center. Also, all or portions of all counties to be served via the proposed 3T MRI are designated by the Health Resources & Services Administration (HRSA) as Medically Underserved Areas (MUA's); such geographies are to be given special consideration by the HSDA when evaluating need.

- 3T MRI technology is fast becoming the standard of care in the community.
- There is a clear and demonstrated need for the project. The project is financially feasible; Erlanger has undergone a tremendous financial turnaround under new leadership and has the funds to implement the project. The addition of the 3T MRI will contribute to the orderly development of health services in the region. Erlanger is an academic medical center and the safety net provider for the region. More than forty hospitals regularly refer patients to Erlanger because of the depth and breadth of services provided.

We appreciate your consideration of this request to place the CON on the Consent Calendar. We understand that our application will be placed in the regular review cycle in the event this request is denied.

Thank you for your consideration.

Sincerely,

Joseph M. Winick, FACHE
Senior Vice President,
Planning & Business Development

CC: Kevin M. Spiegel, FACHE
President & CEO

BACK OF THIS DOCUMENT CONTAINS A WATERMARK - HOLD AT AN ANGLE TO VIEW

erlanger

ERLANGER HEALTH SYSTEM
CHATTANOOGA, TN 37403

FIRST TENNESSEE BANK NAT'L
701 Market Street
Chattanooga, TN 37402
87-36/613

596231

Date Sep/10/2014

Pay Amount $10,321.00***

Pay ****TEN THOUSAND THREE HUNDRED TWENTY-ONE AND XX / 100 DOLLAR****

Void after 60 days

To The Order Of

STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOP AGENCY
500 DEADERICK ST SUITE 850
NASHVILLE, TN 37243

Authorized Signature

Health Services and Dev Agency
Office 31607001
Receipt # 13063018
PAID 9/12/2014
Batch # 678178
Trans # $10,321.00
HA01 CON Filing Fees
Check 21

THANK YOU FOR YOUR PAYMENT

$10,321.00
$10,321.00

⑈596231⑈ ⑆061300367⑆ 00000802 9⑈

STATE OF TENNESSEE
Health Services and Dev Agency
Office 31607001
9/12/2014 10:15 AM

Cashier: annr0811001
Batch #: 678178
Trans #: 1
Workstation: AF0719WP45

CON Filing Fees

Receipt #: 13063018	
HA01 CON Filing Fees	$10,321.00
Payment Total:	**$10,321.00**
Transaction Total:	**$10,321.00**
Check 21	$10,321.00

Thank you for your payment.
Have a nice day!

CN1409-038

SEP 12'14 AM10:11

CERTIFICATE OF NEED APPLICATION

Chattanooga-Hamilton County Hospital Authority

D / B / A

Erlanger Medical Center

Application For

Magnetic Resonance Imaging (Tesla 3.0)

On The Main Campus Of
Erlanger Health System

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

Section A

APPLICANT PROFILE

Section A: APPLICANT PROFILE

Please enter all Section A responses on this form. All questions must be answered. If an item does not apply, please indicate "N/A". ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable item Number on the attachement.***

1. Name of Facility, Agency, or Institution.

Chattanooga-Hamilton County Hospital Authority
D / B / A
Erlanger Medical Center
975 East 3rd Street
Hamilton County
Chattanooga, TN 37403

2. Contact Person Available For Responses To Questions.

Joseph M. Winick, Sr. Vice President
Planning & Business Development
Erlanger Health System
975 East 3rd Street
Chattanooga, TN 37403
(423) 778-8088
(423) 778-7525 -- FAX
Joseph.Winick@erlanger.org -- E-Mail

3. Owner of the Facility, Agency, or Institution.

Chattanooga - Hamilton County Hospital Authority
D / B / A
Erlanger Health System
975 East 3rd Street
Hamilton County
Chattanooga, TN 37403
(423) 778-7000

4. Type of Ownership or Control.

A. Sole Proprietorship _____
B. Partnership _____
C. Limited Partnership _____
D. Corporation (For Profit) _____

E.	Corporation (Not-for-Profit)	
F.	Governmental (State of TN or Political Subdivision)	X
G.	Joint Venture	
H.	Limited Liability Company	
I.	Other (Specify)	

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

-- A copy of the enabling legislation along with a copy of the certification by the Tennessee Secretary of State is attached at the end of this Application.

-- Please note that *Erlanger Health System* is a single legal entity and *Erlanger Medical Center* is an administrative unit of *Erlanger Health System*.

5. Name of Management / Operating Entity (if applicable).

Chattanooga-Hamilton County Hospital Authority
D / B/ A
Erlanger Health System
975 East 3rd Street
Hamilton County
Chattanooga, TN 37403

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. Legal Interest in the Site of the Institution

(Check One)

A.	Ownership	X
B.	Option to Purchase	
C.	Lease of _____ Years	
D.	Option to Lease	
E.	Other (Specify)	

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

7. Type of Institution

(Check as appropriate - more than one response may apply)

A.	Hospital (Specify) General Medical / Surgical	X
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty	
C.	ASTC, Single Specialty	
D.	Home Health Agency	
E.	Hospice	
F.	Mental Health Hospital	
G.	Mental Health Residential Treatment Facility	
H.	Mental Health Institutional Habilitation Facility (ICF/MR)	
I.	Nursing Home	
J.	Outpatient Diagnostic Center	
K.	Recuperation Center	
L.	Rehabilitation Facility	
M.	Residential Hospice	
N.	Non-Residential Methadone Facility	
O.	Birthing Center	
P.	Other Outpatient Facility (Specify) _____	
Q.	Other (Specify) _____	

8. Purpose of Review

(Circle Letter(s) as appropriate - more than one response may apply)

A.	New Institution	
B.	Replacement/Existing Facility	
C.	Modification/Existing Facility	
D.	Initiation of Health Care Service As Defined In TCA § 68-11-1607(4) (Specify) _____ _____	
E.	Discontinuance of OB Services	
F.	Acquisition of Equipment	X
G.	Change in Beds	

[*Please note the type of change by underlining the appropriate response:* Increase, Decrease, Designation, Distribution, Conversion, Relocation]

H. Change of Location _____
I. Other (Specify) _____

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9. Bed Complement Data

Please indicate current and proposed distribution and certification of facility beds.

		Licensed Beds	*(*) CON Beds*	*Staffed Beds*	*Beds Proposed*	*TOTAL Beds at Completion*
A.	Medical	251		144		251
B.	Surgical	193		114		193
C.	Long-Term Care Hospital					
D.	Obstetrical	40		40		40
E.	ICU / CCU	91		91		91
F.	Neonatal	64		64		64
G.	Pediatric	49		49		49
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child / Adolescent Psychiatric					
K.	Rehabilitation					
L.	Nursing Facility (Non – Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid / Medicare)					
P.	ICF / MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds					
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL	688		502		688

(*) CON Beds approved but not yet in service.

*** ***NOTE*** – Erlanger Medical Center operates under Tennessee, Dept. of Health -- License No. 000140.

10. Medicare Provider Number 044-0104

Certification Type General Medical/Surgical

11. Medicaid Provider Number 044-0104 (** See note.)

Certification Type General Medical/Surgical

** Please note that the same provider number for Medicare has been shown for Medicaid as well. This is because the individual TennCare MCO's each assign their own particular provider ID numbers.

12. If this is a new facility, will certification be sought for Medicare and / or Medicaid ?

Yes _____ No _____

** Not Applicable - *Erlanger Medical Center* currently participates in both the Medicare and TennCare/Medicaid programs.

13. Identify all TennCare Managed Care Organizations / Behavioral Health Organizations (MCO's/BHO's) operating in the proposed service area.* Will this project involve the treatment of TennCare participants ?** *Yes* **If the response to this item is yes, please identify all MCO's/BHO's with which the applicant has constracted *or plans to contract.

Discuss any out-of-network relationships in place with MCO's/BHO's in the area.

Response

With the initiation of the *Health Care Exchanges* under the *Affordable Care Act* on January 1, 2014; *Blue Network E* enrolled over 10,000 uninsured people and *Erlanger* is the only provider in this network Further, an additional 7,000 people were enrolled in *Blue Network S* and *Erlanger* is one of only two providers in this network. *Erlanger* is the low cost and safety net provider in the regional service area and participates in narrow networks to facilitate needed care for those who would otherwise not be able to receive it.

Erlanger currently has contracts with the following entities.

A. TennCare Managed Care Organizations

-- BlueCare
-- TennCare *Select*
-- United Healthcare Community Plan
(Children's Medical Services under age 21 & High Risk Maternity Only)
-- AmeriGroup Community Care

B. Georgia Medicaid Managed Care Organizations

-- AmeriGroup Community Care
-- Peach State Health Plan
-- WellCare Of Georgia

C. Commercial Managed Care Organizations

-- Blue Cross / Blue Shield of Tennessee
- Blue Network P
- Blue Network S
- Blue Network E
- Blue CoverTN
- Cover Kids
- AccessTN
- Blue Advantage

-- Blue Cross of Georgia (HMO & Indemnity)
-- Bluegrass Family Health, Inc.
(includes Signature Health Alliance)
-- CIGNA Healthcare of Tennessee, Inc.
(includes LocalPlus)
-- UNITED Healthcare of Tennessee, Inc.
(Commercial & Medicare Advantage)
-- Aetna Health
-- Health Value Management D/B/A Choice Care Network (Commercial & Medicare Advantage)
-- HUMANA (Commercial & Medicare Advantage)
-- HUMANA Military
-- HealthSpring (Commercial & Medicare Advantage)
-- Windsor Health Plan (Medicare Advantage)
-- Olympus Managed Health Care, Inc.

D. Alliances

-- Health One Alliance

E. Networks

-- Multi-Plan (includes Beech Street & PHCS)
-- MCS Patient Centered Healthcare
-- National Provider Network
-- NovaNet (group health)
-- USA Managed Care Corp.
-- MedCost
-- Alliant Health Plan
-- Crescent Preferred Provider Organization
-- Evolutions Healthcare System
-- Prime Health Resources
-- Three Rivers Provider Network
-- Galaxy Health Network
-- First Health Network
-- Integrated Health Plan
-- Logicomp Business Solutions, Inc.
-- HealthSCOPE Benefits, Inc.
-- HealthCHOICE (Oklahoma State & Education Employees Group Insurance Board)

F. Other

-- Alexian Brothers Community Services

Section B

PROJECT DESCRIPTION

Section B: PROJECT DESCRIPTION

Please answer all questions on 8 ½" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

Response

Erlanger Medical Center, the region's safety net provider for adults and children, seeks approval for acquisition of a 3.0 Tesla MRI unit. *EMC's* utilization of the 3 MRI units which we currently have was 11,558 procedures in 2013, with an average utilization per unit of 3,853 procedures. This utilization is 34% higher than optimal capacity of 2,880 procedures per unit (i.e.-80% threshold) and 7% higher than full utilization of 3,600 procedures per unit. On July 2, 2014, we implemented a 3rd shift (i.e.-night shift) in our MRI dept. so that we could keep up with the volume. With such high utilization and inpatients being served during night time hours, this needlessly increases the length of stay and cost of care.

We are performing the MRI scans for inpatients on the 3rd shift, which is not optimal for patient care when they should ideally be resting. This actually may increase the cost of inpatient care to an extent because the length of stay may be longer than it would be otherwise. Ultimately, with the addition of a 4th MRI unit, *EMC* expects that its length of stay and cost of inpatient care may be reduced.

In addition to high utilization, we have a need to perform MRI scans with newer technology for patients that require higher resolution imaging. The newer technology of Tesla 3.0 is becoming the standard of care in imaging such

as Orthopedics, Neurology and Pediatrics. Currently, patients which require this type of imaging are being referred outside the *Erlanger* system of care. In 2013 we referred a total of 759 patients that required 3.0 Tesla imaging.

Currently, *Erlanger's* inability to perform this type of imaging has the potential to negatively impact the care of patients that rely on our position in Southeast Tennessee as the safety net provider. With the initiation of the *Health Care Exchanges* under the *Affordable Care Act* on January 1, 2014; *Blue Network E* enrolled over 10,000 uninsured people and *Erlanger* is the only provider in this network. Further, an additional 7,000 people were enrolled in *Blue Network S* and *Erlanger* is one of only two providers in this network. *Erlanger* is the low cost and safety net provider in the regional service area and participates in narrow networks to facilitate needed care for those who would otherwise not be able to receive it.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. Describe the construction, modification and / or renovation to the facility (exclusive of major medical equipment covered by T.C.A. section 68-11-1601 *et seq.***) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $ 5 million) and other facility projects (construction cost in excess of $ 2 million) should complete the Square Footage And Cost Per Square Foot Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects**

need only complete Part B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above describe the development of the proposal.

Response

The 3.0 Tesla MRI unit will be placed on the 1st floor of *Erlanger's* Outpatient Services Dept. With some of the space currently occupied, the outpatient *Bone Density* and *Ultrasound* areas will be relocated. This space requires a new MRI vault and shielding to be installed and the total area for thes project will be 2,875 SF. No nursing units or other departments will be affected by this project.

B. Identify the number of beds increased, decreased, converted, relocated, designated, and/or distributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

Response

*** Not Applicable. ***

Square Footage & Cost Per Square Foot Chart

The *Square Footage & Cost Per Square Foot Chart* is not applicable to this CON application.

C. As the applicant, describe your need to provide the following healthcare services (if applicable to this application):

1.	Adult Psychiatric Services	N/A
2.	Alcohol and Drug Treatment for Adolescents (exceeding 28 days)	N/A
3.	Birthing Center	N/A
4.	Burn Units	N/A
5.	Cardiac Catheterization Services	N/A
6.	Child and Adolescent Psychiatric Services	N/A
7.	Extracorporeal Lithotripsy	N/A

8.	Home Health Services	N/A
9.	Hospice Services	N/A
10.	Residential Hospice	N/A
11.	ICF/MR Services	N/A
12.	Long-Term Care Services	N/A
13.	Magnetic Resonance Imaging (MRI)	** *See Below.*
14.	Mental Health Residential Treatment	N/A
15.	Neonatal Intensive Care Unit	N/A
16.	Non-Residential Methadone Treatment Centers	N/A
17.	Open Heart Surgery	N/A
18.	Positron Emission Tomography	N/A
19.	Radiation Therapy/Linear Accelerator	N/A
20.	Rehabilitation Services	N/A
21.	Swing Beds	N/A

Response

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D. Describe the need to change location or replace an existing facility.

Response

*** Not applicable. ***

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $ 2.0 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed site major medical equipment (not replacing existing equipment).

   a. Describe the new equipment, including:

      1. Total Cost (as defined by Agency Rule).
      2. Expected useful life.
      3. List of clinical applications to be provided.
      4. Documentation of FDA approval.

   Response

The MRI unit to be acquired is a Siemens Magnetom Skyra 3.0 Tesla system with a total project cost, as defined by Agency rule, of $ 4,597,711. The expected useful life is 5 years. The newer technology of higher resolution imaging with of 3.0 Tesla is becoming the standard of care in imaging for specialties such as Orthopedics, Neurology and Pediatrics. A copy of the letter from the FDA approving this unit for commercial use is attached at the end of this CON application.

b. Provide current and proposed schedules of operations.

Response

The schedule of operation for the Tesla 3.0 unit will be 8:00 am - 8:00 pm, Monday - Saturday. The 3.0 Tesla unit will be open on Saturday's to promote access to the service.

The schedule of operation for the 3 MRI units which we currently have, is as follows. It should be noted that this schedule not only accommodates our high utilization, but also promotes access availability of this service to the community.

Unit No. 1 -	M-F	7 am - 11 pm
	Sa-Su	8 am - 8 pm
Unit No. 2 -	M-F	7 am - 11 pm
Unit No. 3 -	M-F	7 am - 11 pm

2. For mobile major medical equipment:

a. List all sites that will be served.
b. Provide current and proposed schedules of operations.
c. Provide the lease or contract cost.
d. Provide the fair market value of the equipment.
e. List the owner for the equipment.

Response

*** Not Applicable. ***

3. Indicate applicant's legal interest in equipment (i.e.-purchase, lease, etc.). In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

Response

Applicant will purchase the Tesla 3.0 MRI unit from Siemens. A copy of the quote from Siemens is attached to this CON application.

III. (A) Attach a copy of the plot plan of the site on an 8 ½" x 11" sheet of white paper which **must include**:

1. Size of site (**in acres**).

-- The *Erlanger Medical Center* campus is located on approximately 40.7 acres. A copy of the plot plan is attached to this application.

2. Location of structure on the site.

-- Please see the location of the MRI unit within the Outpatient Services Center on the drawing attached to this application.

3. Location of the proposed construction.

-- 975 East 3rd Street
Chattanooga, TN 37403

4. Names of streets, roads or highways that cross or border the site.

-- Roads that border the site are *East*

3rd Street, Hampton Street, Blackford Street, and *Central Avenue.*

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Response

Erlanger Medical Center is easily accessible to patients in Chattanooga and Hamilton County as well as the surrounding service area; from both primary and secondary roads. Additionally, the hospital can be easily accessed via public transportation. Proximal state and interstate highways provide easy access from Tennessee, Georgia, Alabama and North Carolina.

Search Results

From: 975 E 3rd St, Chattanooga, TN 37403-2103
To: US Federal District Court (courthouse), Chattanooga, Tennessee, United States

IV. Attach a floor plan drawing which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc., on an 8 ½" x 11" sheet of white paper.

NOTE: ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

Response

A copy of the floor plan is attached to this application.

V. For a Home Health Agency or Hospice, identify:

A. Existing service area by County.
B. Proposed service area by County.
C. A parent or primary service provider.
D. Existing branches.
E. Proposed branches.

Response

*** Not applicable. ***

Section C

GENERAL CRITERIA FOR CERTIFICATE OF NEED

Section C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines For Growth), developed pursuant to Tennessee Code Annotated § 68-11-1625.

The following questions are listed according to the three (3) criteria: (1) Need, (2) Economic Feasibility, and (3) Contribution to the Orderly Development of Healthcare. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on 8 ½" x 11" white paper*. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)".

PRINCIPLES OF TENNESSEE STATE HEALTH PLAN

[From 2011 Update, Pages 5-13]

1. *Healthy Lives*: The purpose of the State Health Plan is to improve the health of Tennesseans.

Response

Erlanger Medical Center is the safety net hospital for southeast Tennessee; though the hospital also serves northwest Georgia, northeast Alabama and southwest North Carolina due to it's location and the scope and range of services provided. It is often the only hospital which low-income people, minorities, and other underserved populations can turn to for treatment. In order to assure the continued viability of its mission as a safety net hospital, *Erlanger Medical Center* continually strives to provide services that are the most medically appropriate,

least intensive, and provided in the most cost-effective health care setting.

As the safety net provider, a large underserved population depends on *Erlanger* to provide needed services. While it is difficult to predict the outcome of health reform initiatives, many Tennesseans previously without health insurance can be expected to elect services which may have otherwise been postponed, adding to the potential demand for MRI services. Growth in the elderly and general population can also be expected to increase demand for MRI services. Surveys of the Chattanooga region have shown that some 70% or more of area physicians and surgeons received their training at *EMC* via its affiliation with the UT College of Medicine. Based on current residency and fellowship programs, it can be expected that this trend will continue with many physicians opting to remain in Tennessee, at *Erlanger*.

The proposed modifications to *EMC's* physical plant and Imaging services are consistent with the *State Health Plan* because they seek to ensure patient access to appropriate facilities for Tennesseans in particular. *Erlanger Medical Center*, is the safety net hospital for underserved residents in southeast Tennessee, including the only Children's Hospital in the within 100 miles of Chattanooga, Tennessee. Providing enhanced access regardless of the patients' ability to pay has been demonstrated to improve the health status of those served.

The Chattanooga region has proven attractive to business development due to the relatively low cost of labor, cost of living and absence of personal income tax. Also, Chattanooga has been recognized as one of the tenth lowest cost markets from a health care insurance perspective since roll out of the Affordable Care Act and the insurance exchange marketplace.

Volkswagen recently announced that it will invest $600 million in its Chattanooga manufacturing plant, adding a second automobile line to its production facilities. In doing so, Volkswagen expects to employ an additional 2,000 employees, with the goal to have the second production line up and running in 2016. *Erlanger* has a primary care site on the Volkswagen campus that serves employees and their families as well as others in the community. Volkswagen also has preferred employer status with *Erlanger*, whereby

employees receive a discount when services are provided. With this expansion, parts, paint and other suppliers involved with the manufacturing are also expected to add employees. Volkswagen has released an additional 300 acres of property to house as many as twenty additional supply companies, increasing site employment to 7,500. The Erlanger East campus is located about five minutes from the Volkswagen campus and is the closest medical facility to the campus.

Audia International, a Pennsylvania based company engaged in the manufacturing of plastics and related products for the automobile, appliance and packaging industries recently announced that it would construct a new 240,000 SF facility in Walker County, Georgia, a short distance from Chattanooga. The company expects to spend $50 million on the new plant and employ 200 staff.

GE Roper, the appliance division for GE located in LaFayette, Georgia indicated they would make an $88 million investment to expand their plant as part of a GE Appliance initiative to bring jobs back to the United States, insourcing instead of outsourcing. GE expects to spend $1 billion on the plan. Locally, 90 new jobs are expected to be added to 1,500 already employed.

The Coca-Cola Bottling Company has also announced plans to invest $62 million in Hamilton County to build a new 305,000 SF state-of-the-art distribution and sales facility that will add 43 new jobs. Coca-Cola Bottling has been in Chattanooga for over 100 years and currently employ nearly 500 staff. The company hopes to complete the new facility in late 2015.

Plastic Omnium Auto Exteriors, LLC, a tier one supplier for Volkswagen, also recently announced that it will make a $65 million investment in Chattanooga, creating nearly 200 new positions at opening, with a target of 300 positions within three years. The company has purchased 27 acres in the industrial park where VW is located.

NV Michel Van De Wielke, one of the largest manufacturers of textile machines in the world indicated it would relocate to Chattanooga from Dalton, GA, to be closer to marketplace competitors and challenge rivals for market share. The plant will employ 35. Chattanooga is the birthplace of tufting with a long tradition in the flooring

industry and many manufacturers are still in the region. The company will also relocate its headquarters from Charlotte, NC, to Chattanooga.

On the health front, area hospitals have also invested in plant improvements and technology. *Memorial Hospital* has just completed a renovation and expansion project of approximately $ 300 million. *Parkridge Health System*, an affiliate of *HCA Healthcare*, acquired a competitor in the region (*Grandview Hospital*) and recently completed relocation/expansion of its psychiatric facility with approximately approximately $ 8 million invested. *Skyridge Medical Center*, in Bradley County is owned by *Community Health System*, consolidated two facilities and invested approximately $ 45 million in upgrades.

Investment in the region is expected to continue across all industries for the foreseeable future. The Chattanooga Area Chamber of Commerce expects to meet its goal of adding more than 15,000 jobs by the end of 2015.

2. *Access To Care*: Every citizen should have reasonable access to care.

Response

Erlanger Medical Center, is designated by *TennCare* as the safety net hospital, for underserved residents in southeast Tennessee. *Erlanger's* TennCare / Medicaid utilization and uncompensated care cost for the last three (3) fiscal years are presented below.

	TennCare / Medicaid Utilization %	Uncompensated Care Cost
FY 2011	25.9 %	$ 82.9 M
FY 2012	24.7 %	$ 85.5 M
FY 2013	24.1 %	$ 85.1 M

Notes
(1) TennCare / Medicaid utilization percentages are based on gross I/P charges derived from applicant's internal records.
(2) Uncompensated care cost estimates were derived from applicant's internal records as reported in the notes to the annual audited financial statements.
(3) Erlanger's fiscal year begins on July 1 of each year and ends on June 30 of the following year. For example, FY 2014 began on July 1, 2013, and ended on

Under the federal Medicare program, an urban hospital with more than 100 beds needs to serve only 15% of low-income patients in order to qualify as a "disproportionate share hospital". *Erlanger* clearly shoulders significantly more than its proportionate share of the care rendered to this patient population. The State Health Plan favors initiatives, like the project proposed herein, which help to foster access to the underserved.

Erlanger Medical Center has the only Level I trauma center, the only life-flight helicopter service, and the only children's hospital in the region. *Erlanger* is also the only provider in its service area of Level III neonatal care and perinatal services. *Erlanger Health System* is committed to maintaining its mission of providing healthcare services to all citizen's regardless of ability to pay. Such services include inpatient care, obstetrics, surgical services and emergency care.

Erlanger Health System also operates several other hospitals in southeast Tennessee as well as a network of physician offices and *Federally Qualified Health Centers* (hereinafter "FQHC") with three (3) locations, so that patients may easily access needed services while also facilitating easy access to the broader healthcare delivery system.

3. *Economic Efficiencies*: The State's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the state's health care system.

Response

Historically, *EMC* has been very cost efficient within the context of the overall healthcare delivery system. The inpatient net revenue per admission for local competitors in Chattanooga, Tennessee, is as follows.

Hospital	Avg. Net Revenue Per I/P Admission
Erlanger Medical Center	$ 10,579
Memorial Hospital	$ 10,968
Parkridge Medical Center	$ 15,503

Notes
(1) Information derived from Tennessee Joint Annual Reports for CY 2013.

To evidence this, with the initiation of the *Health Care Exchanges* on January 1, 2014; *Blue Network E* enrolled over 10,000 uninsured and *Erlanger* is the only provider in this network. Further, an additional 7,000 people were enrolled in *Blue Network S* and *Erlanger* is one of only two providers in this network as well.

While offering more complex services and capabilities, *Erlanger* has net revenue per inpatient admission lower than other large area hospitals. *Erlanger Medical Center* is economically efficient, while incurring higher costs by offering more complex services including the only Level I trauma center, the only life-flight helicopter service, the only children's hospital, and the only Level III neonatal care in southeast Tennessee.

4. ***Quality Of Care*: Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.**

Response

Erlanger Medical Center , which is accredited by the Joint Commission, participates in periodic submission of quality related data to the *Centers For Medicare & Medicaid Services* through its *Hospital Compare* program. Further, *EMC* has an internal program of *Medical Quality Improvement Committees* which continually monitor healthcare services to assure patients of the quality of care provided.

5. ***Health Care Workforce*: The state should support the development, recruitment, and retention of a sufficient and quality health care workforce.**

Response

Erlanger Health System, as southeast Tennessee's only academic medical center, has established strong long term relationships with the region's colleges, universities and clinical programs. Erlanger provides clinical sites for

internships and rotation programs in nursing, radiology, respiratory care and pharmacy, to name a few. A number of regional universities offer Bachelor degree programs in nursing and physical therapy. Locally, two year degrees are available in many clinical allied health areas with additional programs offering advanced technical training in Radiological Imaging such as Nuclear Medicine and Diagnostic Ultrasonography.

The *University of Tennessee - College of Medicine* is co-located at Erlanger and includes training of senior medical students on clinical rotation as well as graduate medical education for training of residents and advanced fellowships in various medical specialties, including surgical specialties, as outlined below.

Residency Programs

- Emergency Medicine
- Family Medicine
- Internal Medicine
- Obstetrics & Gynecology
- Orthopedic Surgery
- Pediatrics
- Plastic Surgery
- Surgery
- Urology (beginning 2015)
- Transitional Year

Fellowship Programs

- Geriatrics
- Hospice & Palliative Care
- Orthopedic Surgery - Traumatology
- Surgical Critical Care
- Vascular Surgery
- Colon & Rectal Surgery
- Emergency Medicine
- Minimally Invasive Gynecologic Surgery
- Neuro-Interventional Surgery
- Ultrasound
- Cardiology (under development)
- Gastroenterology (under development)

Erlanger Health System participates with numerous schools that provide advanced training in the areas of nursing and allied health.

[End Of Responses To Principles Of Tennessee State Health Plan – 2011 Update, pages 5 - 13]

CRITERIA FOR MAGNETIC RESONANCE IMAGING SERVICES

[From Revised And Updated Standards & Criteria For MRI Services, 2011]

1. Utilization Standards For Non-Specialty MRI Units

a. An applicant proposing a new non-Specialty MRI service should project a minimum of at least 2,160 procedures in the first year of service, building to a minimum of 2,520 procedures per year by the second year of service, and building to a minimum of 2,880 procedures per year by the third year of service and for every year thereafter.

Response

Erlanger Medical Center, the region's safety net provider for adults and children, seeks approval for acquisition of a 3.0 Tesla MRI unit. *EMC's* utilization of the 3 MRI units which we currently have was 11,558 procedures in 2013, with an average utilization per unit of 3,853 procedures. This utilization is 34% higher than optimal capacity of 2,880 procedures per unit (i.e.-80% threshold) and 7% higher than full utilization of 3,600 procedures per unit. On July 2, 2014, we implemented a 3rd shift (i.e.-night shift) in our MRI dept. so that we could keep up with the volume. With such high utilization and inpatients being served during night time hours, this needlessly increases the length of stay and cost of care.

We are performing the MRI scans for inpatients on the 3rd shift, which is not optimal for patient care when they should ideally be resting. This actually may increase the cost of inpatient care to an extent because the length of stay may be longer than it would be otherwise. Ultimately, with the addition of a 4th MRI unit, *EMC* expects that its length of stay and cost of inpatient care may be reduced.

In addition to high utilization, we have a need to perform MRI scans with newer technology for patients

that require higher resolution imaging. The newer technology of 3.0 Tesla is becoming the standard of care in imaging such as Orthopedics, Neurology and Pediatrics. Currently, patients which require this type of imaging are being referred outside the *Erlanger* system of care. In 2013 we referred a total of 759 patients that required 3.0 Tesla imaging.

The projected volume for the 3.0 Tesla unit is as follows.

	Year 1	Year 2	Year 3
Orthopedic (3T)	760	825	825
Neurologic (3T)	325	375	400
Pediatric (3T)	325	325	450
Other (3T)	275	275	525
Sub-Total - 3T	1,685	2,050	2,200
Re-Allocation	665	925	950
Total	2,350	2,975	3,150

Notes

(1) The other 3T volume estimate includes Cardiac, Urology, and Women's Health.

(2) While the 3T volume estimates are expected to grow, it could be at a faster rate than the estimates in this table.

(3) The re-allocation volume is that which can be moved from EMC's 3 other MRI units due to over capacity.

b. Providers proposing a new non-Specialty mobile MRI service should project a minimum of at least 360 mobile MRI procedures in the first year of service per day of operation per week, building to an annual minimum of 420 procedures per day of operation per week by the second year of service, and building to a minimum of 480 procedures per day of operation per week by the third year of service and for every year thereafter.

Response

*** Not applicable. ***

c. An exception to the standard number of procedures may occur as new or improved technology and equipment or new diagnostic applications for MRI units are developed. An applicant must demonstrate that the proposed unit offers a unique and necessary technology for the provision of health care services in the Service Area.

Response

While *EMC* has demonstrated that the standard number of procedures will be met for this unit, as such, an exception to the standard is not needed. However, we simply wish to point out that 3.0 Tesla imaging is becoming the standard for certain medical specialties such as Orthopedics, Neurology and Pediatrics. Therefore, it essentially becomes an access issue since *Erlanger* is the safety net provider in Southeast Tennessee. As such, uninsured and vulnerable populations may not otherwise have access to this technology.

d. Mobile MRI units shall not be subject to the need standard in paragraph 1(b) if fewer than than 150 days of service per year are provided at a given location. However, the applicant must demonstrate that existing services in the applicant's Service Area are not adequate and/or that there are special circumstances that require these additional services.

Response

*** Not applicable. ***

e. Hybrid MRI Units. The HSDA may evaluate a CON application for an MRI "hybrid" Unit (an MRI unit that is combined/utilized with another medical equipment such as a megavoltage radiation therapy unit or a positron emission tomography unit) based on the primary purposes of the Unit.

Response

*** Not applicable. ***

2. **Access to MRI Units. All applicants for any proposed new MRI Unit should document that the proposed location is accessible to approximately 75% of the Service Area's population. Applications that include non-Tennessee counties in their proposed Service Areas should provide evidence of the number of existing MRI units that service the non-Tennessee counties and the impact on MRI unit utilization in the non-Tennessee counties, including the specific location of those units located in the non-Tennessee counties, their utilization rates, and their capacity (if that data are available).**

Response

The service area for the MRI service is most likely to be Southeast Tennessee and Northwest Georgia. However, for purposes of our need evaluation we have not included Northwest Georgia in our analysis because the utilization data for MRI units located in that geography is not available from the Georgia Dept. of Community Health website. The ten (10) counties which represent the service area in Southeast Tennessee are as follows.

Hamilton County, Tennessee
Bradley County, Tennessee
Marion County, Tennessee
Grundy County, Tennessee
Sequatchie County, Tennessee
Bledsoe County, Tennessee
Meigs County, Tennessee
Rhea County, Tennessee
McMinn County, Tennessee
Polk County, Tennessee

The furthest point of the service area (i.e.-the ten (10) counties in Southeast Tennessee) is approximately 67 miles from EMC's main campus, this represents a maximum driving time of approximately 1 hour and 20 minutes for 100 % of the service area population. For 75% of the service area population the driving time would be approximately 40 minutes or less for a distance of approximately 34 miles.

3. **Economic Efficiencies. All applicants for any proposed new MRI unit should document that alternate shared services and lower cost technology applications have been investigated and found less advantageous in terms of accessibility, availability, continuity, cost, and quality of care.**

Response

Applicant has evaluated alternatives and found them not to be optimal in light of our mission to serve those who do not otherwise have access to health services, such as the uninsured, low income and vulnerable populations.

The reasons for acquiring a 3.0 Tesla MRI unit are that the technology is, 1.) becoming the standard of care in some medical specialties such as Orthopedics; 2.) *EMC's* other 3 MRI units are over capacity and unable to keep up with demand for this imaging service, 3.) patient schedules are delayed and length of stay is increased by our high utilization, and 4.) *EMC's* mission to provide the appropriate level of service to uninsured, low income and vulnerable populations will be further enhanced.

The broad healthcare system, and *EMC* specifically, will achieve economic efficiencies from the acquisition of a 3.0 Tesla MRI unit. The efficiencies to be gained are that patients will not have to be referred outside of *EMC's* system of care … in other words, transportation cost to another facility, waiting time to be served and inter-provider communications. Making *EMC* more efficient makes the healthcare system in Southeast Tennessee more efficient.

4. **Need Standard For Non-Specialty MRI Units.**

A need likely exists for one additional non-specialty MRI unit in a Service Area when the combined average utilization of existing MRI service providers is at or above 80% of the total capacity of 3,600 procedures, during the most recent twelve-month period reflected in the provider medical equipment report maintained by the HSDA. The total capacity per MRI unit is based upon the following formula:

Stationary MRI Units: 1.20 procedures per hour x

twelve hours per day x 5 days per week x 50 weeks per year = 3,600 procedures per year

Mobile MRI Units: Twelve (12) procedures per day x days per week in operation x 50 weeks per year. For each day of operation per week, the optimal efficiency is 480 procedures per year, or, 80 percent of the total capacity of 600 procedures per year.

Response

Erlanger Medical Center, the region's safety net provider for adults and children, seeks approval for acquisition of a 3.0 Tesla MRI unit. *EMC's* utilization of the 3 MRI units which we currently have was 11,558 procedures in 2013, with an average utilization per unit of 3,853 procedures. This utilization is 34% higher than optimal capacity of 2,880 procedures per unit (i.e.-80% threshold) and 7% higher than full utilization of 3,600 procedures per unit. On July 2, 2014, we implemented a 3rd shift (i.e.-night shift) in our MRI dept. so that we could keep up with the volume. With such high utilization and inpatients being served during night time hours, this needlessly increases the length of stay and cost of care.

We are performing the MRI scans for inpatients on the 3rd shift, which is not optimal for patient care when they should ideally be resting. This actually may increase the cost of inpatient care to an extent because the length of stay may be longer than it would be otherwise. Ultimately, with the addition of a 4th MRI unit, *EMC* expects that its length of stay and cost of inpatient care may be reduced.

In addition to high utilization, we have a need to perform MRI scans with newer technology for patients that require higher resolution imaging. The newer technology of 3.0 Tesla is becoming the standard of care in imaging such as Orthopedics, Neurology and Pediatrics. Currently, patients which require this type of imaging are being referred outside the *Erlanger* system of care. In 2013 we referred a total of 759 patients that required 3.0 Tesla imaging.

In 2013, for the 30.2 MRI units in Southeast Tennessee, utilization is as follows.

		EHS -- Analysis Of MRI Utilization In Southeast Tennessee			
County	**Type**	**Facility Name**	**No. Of MRI Units**	**Total Proc's**	**Avg. Proc's Per Unit**
Bradley	HOSP	Skyridge Medical Center	1.0	2,302	2,302
Bradley	HOSP	Skyridge Medical Center - Westside	2.0	1,818	909
Hamilton	ODC	Chattanooga Imaging Downtown	2.0	1,540	770
Hamilton	RPO	Chattanooga Imaging East	1.0	2,822	2,822
Hamilton	RPO	Chattanooga Imaging Hixson	1.0	2,386	2,386
Hamilton	ODC	Chatt. O/P Center	2.0	7,292	3,646
Hamilton	H-Imaging	Erlanger East Imaging	1.0	568	568
Hamilton	HOSP	Erlanger Medical Center	3.0	11,558	3,853
Hamilton	HOSP	Memorial Hixson Hospital	2.0	2,488	1,244
Hamilton	HOSP	Memorial Hospital	3.0	4,356	1,452
Hamilton	H-Imaging	Memorial Ooltewah Imaging Center	1.0	1,049	1,049
Hamilton	HOSP	Parkridge East Hospital	1.0	1,024	1,024
Hamilton	HOSP	Parkridge Medical Center	1.0	2,054	2,054
Hamilton	RPO	Tennessee Imaging and Vein Center	1.0	3,165	3,165
Marion	HOSP	Parkridge West Hospital	1.0	884	884
McMinn	HOSP	Starr Regional Medical Center	1.0	2,437	2,437
McMinn	HOSP	Starr Regional Medical Center - Etowah	1.0	479	479
Polk	HOSP	Copper Basin Medical Center	0.2	250	250
Rhea	HOSP	Rhea Medical Center	1.0	1,481	1,481
		Sub - Total	26.2	49,953	1,907
Bradley	PO	Cleveland Imaging	1.0	3,509	3,509
Hamilton	PO	Chattanooga Bone & Joint Surgeons, PC	1.0	841	841
Hamilton	PO	Chattanooga Orthopaedic Group PC	1.0	5,340	5,340
Hamilton	PO	Neurosurgical Group of Chattanooga, P.C.	1.0	1,198	1,198
		Sub - Total	4.0	10,888	2,722
		Total	30.2	60,841	2,015

Notes

(1) MRI utilization data obtained from the *Tennessee Health Services Agency* website. Utilization data is for 2013.

While some of the MRI units in the regional service area are below the threshold of 2,880 procedures per unit, as the safety net provider in Southeast Tennessee, *EMC* has a significant need to provide the 3.0 Tesla imaging technology to the low income, uninsured and vulnerable populations which we serve. Without *Erlanger* having this newer 3.0 Tesla technology these patient categories would likely not have access while it is becoming the standard of care for some medical specialties.

5. Need Standards For Specialty MRI Units.

a. Dedicated fixed or mobile breast MRI unit.

b. Dedicated fixed or mobile Extremity MRI Unit.

c. Dedicated fixed or mobile Multi-position MRI Unit.

Response

** Not Applicable. **

6. Separate Inventories for Specialty MRI Units and non-Specialty MRI Units.

If data availability permits, Breast, Extremity, and Multi-position MRI Units shall not be counted in the inventory of non-Specialty fixed or mobile MRI Units, and an inventory for each category of Specialty MRI Unit shall be counted and maintained separately. None of the specialty MRI Units may be replaced with non-Specialty MRI fixed or mobile MRI Units and a Certificate of Need granted for any of these Specialty MRI Units shall have included on its face a statement to that effect. A non-Specialty fixed or mobile MRI Unit for which a CON is granted for Specialty MRI Unit purpose use-only shall be counted in the specific Specialty MRI Unit inventory and shall also have stated on the face of its Certificate of Need that it may not be used for non-Specialty MRI purposes.

Response

** Not Applicable. **

7. Patient Safety & Quality Of Care.

a. The United States Food & Drug Administration must certify the proposed MRI Unit for clinical use.

Response

A copy of the letter from the FDA approving the Siemens unit for commercial use is attached to this CON application.

b. The applicant should demonstrate that the proposed MRI procedures will be offered in a physical environment that conforms to applicable

federal standards, manufacturer's specifications, and licensing agencies' requirements.

Response

A copy of Architect's letter is attached to this CON application which documents that the physical environment and all appropriate standards, manufacturer specifications and other regulatory requirements will be met.

c. **The applicant should demonstrate how emergencies within the MRI Unit facility will be managed in conformity with accepted medical practice.**

Response

A copy of EMC's policy pertaining to emergencies in the MRI dept. is attached to this CON application.

d. **The applicant should establish protocols that assure that all MRI Procedures performed are medically necessary and will not unnecessarily duplicate other services.**

Response

A copy of EMC's policy pertaining to medical necessity in the MRI dept. is attached to this CON application.

e. **An applicant proposing to acquire any MRI Unit or institute any MRI service, including Dedicated Breast and Extremity MRI Units, shall demonstrate that it meets or is prepared to meet the staffing recommendations and requirements set forth by the American College of Radiology, including staff education and training programs.**

Response

EMC currently operates 3 MRI units and meets all of the staffing recommendations and requirements set forth by the American College of Radiology, including staff

education and training. The same standards will be applicable to the 3.0 Tesla MRI unit.

f. All applicants shall commit to obtain accreditation from the Joint Commission, the American College of Radiology, or a comparable accreditation authority for the MRI within two years following operation of the proposed MRI Unit.

Response

EMC currently operates 3 MRI units and is accredited by The Joint Commission. The same standards will be applicable to the 3.0 Tesla MRI unit.

g. All applicants should seek and document emergency transfer agreements with local area hospitals, as appropriate. An applicant's arrangements with its physician medical director must specify that said physician be an active member of the subject transfer agreement hospital medical staff.

Response

As the tertiary referral center and safety net provider for Southeast Tennessee, *EMC* maintains transfer agreements with many hospitals in the regional service area. The medical director for the 3.0 Tesla unit, Blaise Baxter, M.D., is an active member of EMC's medical staff.

8. The applicant should provide assurances that it will submit data in a timely fashion as requested by the HSDA to maintain the HSDA Equipment Registry.

Response

EMC currently operates 3 MRI units and reports utilization data to the HSDA Equipment Registry. The same standards will be applicable to the 3.0 Tesla MRI unit.

9. In light of Rule 0720-11.01, which lists the factors concerning need on which an application may be

evaluated , and principle no. 2 in the State Health Plan, "Every citizen should have reasonable access to health care", the HSDA may decide to give special consideration to an applicant:

a. Who is offering the service in a medically underserved area as designated by the United States Health Resources & Services Administration;

Response

All ten (10) counties in the service area in Southeast Tennessee, have been designated by HRSA as being medically underserved. A copy of the HRSA designation is attached to this CON application.

b. Who is a "safety net hospital" or a "chldren's hospital" as defined by the Bureau of TennCare Essential Access Hospital payment program; or

Response

Erlanger is classified by the Bureau of TennCare as a "safety net hospital" and also as a "children's hospital".

Erlanger is an Academic Medical Center affiliated with the University of Tennessee - College of Medicine. Erlanger is the only tertiary service provider within 100 miles of Chattanooga, Tennessee. *Erlanger* qualifies under this criterion as a "safety net hospital" because we provide service to all people regardless of their ability to pay. Further, we have the only "children's hospital" within 100 miles of Chattanooga, Tennessee.

c. Who provides a written commitment of intention to contract with at least one TennCare MCO and, if providing adult services, to participate in the Medicare program; or

Response

Erlanger currently contracts with several TennCare MCO's, as follows.

-- BlueCare
-- TennCare Select
-- United Healthcare Community Plan
-- AmeriGroup Community Care

d. Who is proposing to use the MRI Unit for patients that typically require longer preparation and scanning times (e.g.-pediatric, special needs, sedated, and contrast agent use patients). The applicant shall provide in its application information supporting the additional time required per scan and the impact on the need standard.

Response

Erlanger is classified by the Bureau of TennCare as a "safety net hospital" and also as a "children's hospital". *EMC's* experience is that it takes approximately 30 to 45 minutes longer in preparation time for children and patients that are sedated. This contributes to EMC's over capacity, however, we must serve these populations regardless of the patient's ability to pay. The suggested impact on the need standard may be to reduce the full utilization standard to something less than 3,600 when children are served.

[End Of Responses To Revised & Updated Standards & Criteria For MRI Services, 2011]

GENERAL QUESTIONS CONCERNING NEED, ECONOMIC FEASIBILITY & CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE

(I.) *NEED*

1. Describe the relationship of this proposal toward the implementation of the State Health Plan, Teneessee's Health: Guidelines For Growth.

(a) Please provide a response to each criterion and

standard in Certificate Of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

Response

This project is consistent with the *Principles Of The Tennessee State Health Plan* as stated in the 2011 update ("Principles"). *Applicant* has addressed each of the Principles.

(b) Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c).

Response

** Not applicable. **

2. Describe the relationship of this proposal to the applicant facility's long range development plans, if any.

Response

Erlanger Health System currently holds a CON for expansion of the *Erlanger East* campus (No. CN0405-047AE); a CON to modernize and upgrade the surgical facilities at *Erlanger's* main campus (No. CN1207-034A); and a CON for a new PET/CT unit at *Erlanger's* main campus (No. CN1307-027A).

The goal for *Erlanger Health System* is to provide a comprehensive system of care comprised of unduplicated services while also serving those who are currently under served and/or those who do not have the ability to pay for their services. The 3.0 Tesla MRI project is part of this long term plan.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit

maps on 8 ½" x 11" sheets of white paper marked only with ink detectable by a standard photocopier (i.e-no highlighters, pencils, etc.).

Response

The service area for the 3.0 Tesla MRI unit is as follows,

Primary Service Area

Hamilton County, Tennessee

Secondary Service Area

Bradley County, Tennessee
Marion County, Tennessee
Grundy County, Tennessee
Sequatchie County, Tennessee
Bledsoe County, Tennessee
McMinn County, Tennessee
Rhea County, Tennessee
Meigs County, Tennessee
Polk County, Tennessee

The service area is reasonable considering that *Erlanger* currently serves as the largest primary and tertiary based provider in Southeast Tennessee. *Erlanger Health System* makes available to the outlying communities services that otherwise would not be available. It should be noted that Erlanger attracts patients from a much wider geography including Alabama, Georgia and North Carolina.

The service area is reasonable because 48.8 % of the inpatient volume comes from Hamilton County, Tennessee, and 23.3 % of the inpatient volume comes from the 9 county secondary service area, as illustrated below. The precise origin of patients within the service area is detailed as follows for both *Erlanger Health System* as well as the regional service area.

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	EHS – Tesla 3.0 MRI Service Area In-Patient Origin & Market Share – CY 2013				
	Total Erlanger	Total All Other	Total Svc. Area	% EHS Pt. Origin	% Svc. Area Pt. Origin
Hamilton County, TN	13,978	22,980	36,958	48.8%	59.1%
Bradley County, TN	1,873	2,922	4,795	6.5%	7.6%
Marion County, TN	821	1,711	2,532	2.9%	4.0%
Grundy County, TN	263	1,975	2,238	0.9%	3.6%
Sequatchie County, TN	1,043	1,639	2,682	3.6%	4.3%
Bledsoe County, TN	520	631	1,151	1.8%	1.8%
Rhea County, TN	1,148	2,830	3,978	4.0%	6.4%
Meigs County, TN	245	1,257	1,502	0.9%	2.4%
McMinn County, TN	398	4,826	5,224	1.4%	8.4%
Polk County, TN	385	1,107	1,492	1.3%	2.4%
Total - Region	20,674	41,878	62,552	72.1%	100.0%
% Market Share	33.1%				
Outside Service Area	7,994			27.9%	
Total - EHS	28,668			100.0%	

Notes
(1) Facility volume information is derived from the THA Health Information Network market share database for calendar year 2013, which does not include both *Hutcheson Medical Center* and *Skyridge Medical Center*.

A map showing the primary and secondary service areas is attached to this CON application.

4. A. Describe the demographics of the population to be served by this proposal.

Response

The service area of the applicant is defined above. Following is a discussion of certain population trends.

	2014 Est. Pop.	2019 Est. Pop.	2013 Service Area Patient Origin
Hamilton County, TN	345,586	357,660	59.1 %
Bradley County, TN	102,186	106,429	7.6 %
Marion County, TN	28,373	28,562	4.0 %
Grundy County, TN	13,499	13,241	3.6 %
Sequatchie County, TN	14,973	16,104	4.3 %

Bledsoe County, TN	12,998	13,162	1.8 %
Rhea County, TN	32,773	34,049	6.4 %
Meigs County, TN	12,018	12,365	2.4 %
McMinn County, TN	53,187	54,412	8.4 %
Polk County, TN	17,080	17,427	2.4 %
	632,673	653,411	100.0 %

Notes
(1) 2014 and 2019 population figures based on original data from *Claritas* and projected forward by EHS.
(2) 2013 service area patient origin figures were derived from the THA Health Information Network database.

The proposed 3.0 Tesla MRI unit fills an essential gap in diagnostic capability in a number of service lines at *EMC* including Orthopedics, Neurology and Pediatrics because it is becoming the standard of care for these medical specialties. In these services, *EMC* already provides clinical leadership that is recognized in the region and beyond. For example, in neurosciences, the stroke program at *EMC* is recognized as one of the leading programs of its kind in the nation. Volume of patients served places it at the top of the list nationally. Further, *EMC* recently implemented an Epilepsy monitoring unit which will utilize the Tesla 3.0 MRI unit.

The elderly and women are prime candidates for service within the Neuroscience service line. It is estimated that the population age 65 and over in the service area will increase from 117,435 in 2014 to 137,384 in 2019. This is an increase of 17.0%. Thus, the project envisioned by the instant application is intended to be of direct benefit to the senior population.

Women of child bearing age (i.e.-age 15-44) will comprise 37.6 % of the population. Further, 18.8 % of the population will be minority (i.e.-Black, Hispanic, Asian, etc.). *Erlanger* is committed to serving the population within the service area, as well as minorities and other underserved populations. For this reason, *Erlanger* will continue to offer services which may not otherwise be available.

Growth in the service area could exceed forecasts given the attractiveness of southeast Tennessee to large employers such as VW, Amazon and Wacker Chemical, which have already located in the area.

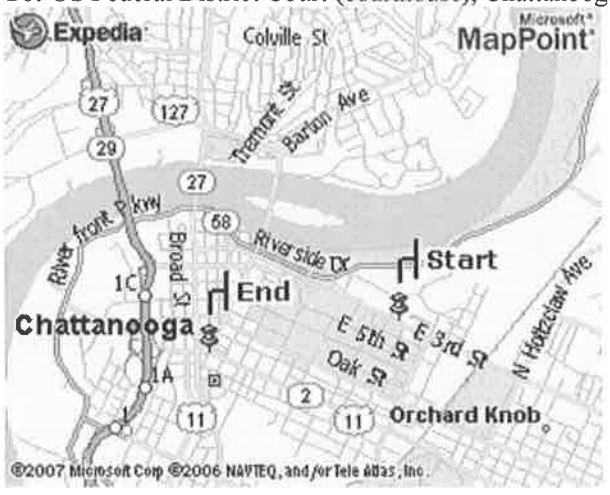
B. The special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response

Erlanger Medical Center is the safety net hospital for southeast Tennessee, and is often the only hospital which low-income people, minorities, and other underserved populations can turn to for treatment. In order to assure the continued viability of its mission as a safety net hospital, *Erlanger Health System* continually strives to provide services that are medically appropriate, least intensive (restrictive), and provided in the most cost-effective health care setting.

Erlanger Medical Center is accessible to patients in Chattanooga and Hamilton County from both primary and secondary roads. Additionally, the hospital can be easily accessed via public transportation. Further, proximal state and interstate highways provide easy access from Tennessee, Georgia and Alabama.

Search Results
From: 975 E 3rd St, Chattanooga, TN 37403-2103
To: US Federal District Court (courthouse), Chattanooga, Tennessee, United States



Erlanger has also been responsive to the needs of new businesses like VW, Amazon and Wacker Chemical which

have generated thousands of new jobs in the area. The proposed project will help ensure that the service area population has access to services and facilities consistent with their needs and evolving industry standards.

It is estimated that the population age 65 and over in the service area will increase from 117,435 in 2014 to 137,384 in 2019. This is an increase of 17.0%. Thus, the project envisioned by the instant application is intended to be of direct benefit to the senior population.

Women of child bearing age (i.e.-age 15-44) will comprise 37.6 % of the population. Further, 18.8 % of the population will be minority (i.e.-Black, Hispanic, Asian, etc.). *Erlanger* is committed to serving the population within the service area, as well as minorities and other under served populations. For this reason, *Erlanger* will continue to offer services which may not otherwise be available.

5. Describe the existing or certified services, including approved but unimplemented CON's, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utlilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

Response

Parkridge Medical Center has filed a CON application for a Tesla 3.0 MRI unit (No. CN1408-035), however, this application has not yet been approved.

Utilization data for the three (3) general acute care hospitals in Chattanooga, Tennessee, is presented below.

	Primary Acute Cate Hospitals -- Chattanooga, Tennessee General Utilization Trends								
	========== 2011 =========			========== 2012 =========			========== 2013 =========		
	Erlanger Med Ctr	Memorial Hospital	Parkridge Med Ctr	Erlanger Med Ctr	Memorial Hospital	Parkridge Med Ctr	Erlanger Med Ctr	Memorial Hospital	Parkridge Med Ctr
General Acute Care - Admissions	26,343	20,963	7,679	27,238	21,395	8,270	27,579	20,580	8,145
Inpatient Pt. Days - Acute Care	131,630	99,911	39,539	133,260	99,485	40,134	130,947	95,924	39,074
General Acute Care - ALOS	5.00	4.77	5.15	4.89	4.65	4.85	4.75	4.66	4.80
ED Visits	89,808	47,946	30,990	91,254	48,322	35,657	92,413	46,213	33,926
Total Surgical Patients	31,266	19,988	9,918	31,492	19,808	10,684	35,490	19,205	13,264
OB Deliveries	2,639	0	0	2,679	0	0	2,692	0	0

NOTES
(1) This information is derived from *Tennessee Joint Annual Reports*.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

Response

Utilization data for *Erlanger Medical Center* is presented below.

				========== Projected Utilization ==========				
	2011	2012	2013	2014	2015	2016	2017	2018
General Acute Care - Admissions	26,343	27,238	27,579	27,788	27,997	28,206	28,416	28,625
Inpatient Pt. Days - Acute Care	131,630	133,260	130,947	130,556	131,538	132,520	133,503	134,485
General Acute Care - ALOS	5.00	4.89	4.75	4.70	4.70	4.70	4.70	4.70
ED Visits	89,808	91,254	92,413	92,300	92,995	93,689	94,383	95,078
Total Surgical Patients	31,266	31,492	35,490	35,759	36,028	36,297	36,566	36,835
OB Deliveries	2,639	2,679	2,692	2,712	2,732	2,753	2,773	2,794

NOTES
(1) This information is derived from *Tennessee Joint Annual Report*, for 2011, 2012 and 2013.
(2) The *Joint Annual Report* information for *Erlanger Medical Center* includes pediatric utilization.

The projected utilization is based upon a use rate average calculation for the three (3) year period of 2010, 2011 and 2012. Expected growth could exceed this forecast based on hospital referral patterns, health reform initiatives and advances in clinical care.

(II.) *ECONOMIC FEASIBILITY*

1. **Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.**

   - **All projects should have a project cost of at least $ 3,000 on Line F (minimum CON filing fee). CON filing fee should be calculated from Line D. (See application instructions for filing fee.)**

   - **The cost of any lease should be based on fair market value or the total amount of lease payments over the initial term of the lease, whichever is greater.**

   - **The cost of fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.**

   - **For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.**

   Response

   The Project Cost Chart has been completed on the next page.

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PROJECT COST CHART

A.	Construction And Equipment Acquired By Purchase.		
	1.	Architecural And Engineering Fees	93,908
	2.	Legal, Administrative, Consultant Fees (Excluding CON Filing Fees)	0
	3.	Acquisition Of Site	0
	4.	Preparation Of Site	0
	5.	Construction Costs	1,030,203
	6.	Contingency Fund	240,317
	7.	Fixed Equipment (Not Included In Construction Contract)	3,013,702
	8.	Moveable Equipment (List all equipment over $ 50,000)	45,604
	9.	Other (Specify) Technical, Signage, Environmental, etc.	163,656
B.	Acquisition By Gift, Donation, Or Lease.		
	1.	Facility (inclusive of building and land)	0
	2.	Building Only	0
	3.	Land Only	0
	4.	Equipment (Specify) _____	0
	5.	Other (Specify) _____	0
C.	Financing Costs And Fees.		
	1.	Interim Financing	0
	2.	Underwriting Costs	0
	3.	Reserve For One Year's Debt Service	0
	4.	Other (Specify) _____	0
D.	Estimated Project Cost	(A + B + C)	4,587,390
E.	CON Filing Fee		10,321
F.	Total Estimated Project Cost	(D + E)	4,597,711

2. Identify the funding sources for this project.

a. Please check the applicable item(s) below and briefly summarize how the project will be financed. (Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)

___ A. Commercial loan -- Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions.

___ B. Tax - Exempt Bonds -- Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance.

___ C. General obligation bonds -- Copy of resolution from issuing authority or minutes from the appropriate meeting.

___ D. Grants -- Notification of intent form for grant application or notice of grant award.

_X_ E. Cash Reserves - Appropriate documentation from Chief Financial Officer.

___ F. Other - Identify and document funding from all other sources.

Response

The project will be funded through internal cash reserves of *Erlanger Health System*. The CFO letter is attached to this CON application.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services And Development Agency.

Response

Applicant believes the cost of the project is reasonable. An analysis of the cost per square foot with similar projects in Tennessee supports this conclusion.

Facility	CON Number	Cost Per Square Foot
Parkridge Medical Center	CN1408-035	$ 433.53
Valley Open MRI	CN1407-028	$ 222.00

The cost estimate for the *EMC* Tesla 3.0 MRI unit has been certified by William H. Wilkerson, Tennessee Architectural License No. 8710, via letter dated Sept. 4, 2014 (copy attached). The cost per SF is $ 358.33.

4. Complete Historical and Projected Data Charts on the following two pages - *Do not modify the Charts provided or submit Chart substitutions* ! Historical Data Chart represents revenue and expense information for the last *three* (3) years for which complete information is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the *Proposal Only* (i.e.-if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).

Response

The financial audit for the current fiscal year ended June 30, 2014, is currently underway and is expected to show a positive financial result.

The *Other Expenses* category of the *Projected Data Chart* is detailed in a separate schedule directly following the *Projected Data Chart*.

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in ___July___ (Month).

		Year – 2011	Year - 2012	Year – 2013
A.	Utilization Data (Specify Unit Of Measure) I/P Admits	27,931	28,987	29,066
B.	Revenue From Services To Patients			
	1. Inpatient Services	960,901,050	971,094,413	951,407,744
	2. Outpatient Services	540,147,249	600,067,032	638,832,332
	3. Emergency Services	112,357,719	112,850,427	122,125,184
	4. Other Operating Revenue (Specify) Home Health, POB Rent, etc.	34,980,484	37,187,604	33,499,831
	Gross Operating Revenue	1,648,386,502	1,721,199,476	1,745,865,091
C.	Deductions From Operating Revenue			
	1. Contractual Adjustments	929,699,718	980,425,997	997,920,752
	2. Provision For Charity Care	79,608,206	78,323,761	102,150,881
	3. Provision For Bad Debt	85,619,511	99,422,380	74,808,470
	Total Deductions	1,094,927,435	1,158,172,138	1,174,880,103
	NET OPERATING REVENUE	553,459,067	563,027,338	570,984,988
D.	Operating Expenses			
	1. Salaries And Wages	271,178,059	277,849,780	275,109,764
	2. Physician's Salaries And Wages	30,609,413	35,148,510	36,117,461
	3. Supplies	76,612,829	79,185,467	78,028,042
	4. Taxes	597,507	553,433	536,994
	5. Depreciation	25,799,614	26,569,378	27,373,556
	6. Rent	2,816,717	3,632,579	5,341,116
	7. Interest - Other Than Capital	0	0	0
	8. Other Expenses (Specify) Insurance, Purch. Svcs., etc.	140,157,885	149,478,971	156,440,656
	Total Operating Expenses	547,772,024	572,418,118	578,947,589
E.	Other Revenue (Expenses) - Net (Specify) _____			
	NET OPERATING INCOME (LOSS)	5,687,043	(9,390,780)	(7,962,601)
F.	Capital Expenditures			
	1. Retirement Of Principal	7,824,776	7,396,156	7,900,842
	2. Interest	9,876,593	9,652,060	8,971,728
	Total Capital Expenditures	17,701,369	17,048,216	16,872,570
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	(12,014,326)	(26,438,996)	(24,835,171)

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PROJECTED DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in ___July___ (Month).

		Year 1	Year 2
A.	Utilization Data	2,350	2,975
	(Specify Unit Of Measure) MRI Procedures		
B.	Revenue From Services To Patients		
	1. Inpatient Services		
	2. Outpatient Services	8,492,065	11,227,918
	3. Emergency Services		
	4. Other Operating Revenue		
	(Specify) _____		
	Gross Operating Revenue	8,492,065	11,227,918
C.	Deductions From Operating Revenue		
	1. Contractual Adjustments	6,569,444	8,758,777
	2. Provision For Charity Care	115,542	152,766
	3. Provision For Bad Debt	251,282	332,236
	Total Deductions	6,936,268	9,243,779
	NET OPERATING REVENUE	1,555,797	1,984,139
D.	Operating Expenses		
	1. Salaries And Wages	240,435	250,774
	2. Physician's Salaries And Wages		
	3. Supplies	19,580	25,586
	4. Taxes		
	5. Depreciation	431,301	431,301
	6. Rent		
	7. Interest - Other Than Capital		
	8. Management Fees:		
	a. Fees To Affiliates		
	b. Fees To Non-Affiliates		
	9. Other Expenses	365,590	413,329
	(Specify) Contrast Agent, Svc. Contract, etc.		
	Total Operating Expenses	1,056,636	1,120,990
E.	Other Revenue (Expenses) – Net		
	(Specify) _____		
	NET OPERATING INCOME (LOSS)	499,161	863,149
F.	Capital Expenditures		
	1. Retirement Of Principal		
	2. Interest		
	Total Capital Expenditures		
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	499,161	863,149

	PROJECTED DATA CHART - OTHER EXPENSES		
		Year 1	Year 2
Other Expenses Category			
1.)	MRI Contrast Agent	116,964	153,358
2.)	Injector	3,800	3,939
3.)	Service Agreement	160,225	166,073
4.)	Corporate Overhead Allocation	84,601	89,959
5.)			
6.)			
7.)			
	Total - Other Expenses	365,590	413,329

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

Response

Following are the average charge amounts per patient.

Average Gross Charge	$ 4,337
Average Deduction From Revenue	
Medicare	$ 4,021
TennCare / Medicaid	$ 3,026
Average Net Revenue	
Medicare	$ 449
TennCare / Medicaid	$ 582

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges of projects that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Response

Please see the list of average patient charges by DRG for *Erlanger Health System* and other acute care providers in Hamilton County, Tennessee, for the calendar year 2013, attached to this CON application. Applicant does revise it's patient charge structure on a periodic basis (i.e.- usually annually) during the budget cycle each fiscal year. However, applicant does not anticipate any changes to existing patient charges specifically as a result of this project.

B. Compare the proposed charges to those of other facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services And Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response

Please see the list of average patient charges by DRG for *Erlanger Health System* and other acute care providers in Hamilton County, Tennessee, for the calendar year 2013, attached to the this CON application.

Per the attached list of average patient charges, following are the average charge per case for each facility for 2013.

Erlanger Medical Center	$ 37,396
Memorial Hospital	$ 40,269
Parkridge Medical Center	$ 61,289
Erlanger East	$ 9,085
Memorial Hospital - Hixson	$ 25,131
Parkridge East Hospital	$ 29,292

7. Discuss how projected utilization rates will be sufficient to maintain cost effectiveness.

Response

Historically, EMC has been very cost efficient within the context of the overall healthcare delivery system. The

inpatient net revenue per admission for local competitors in Chattanooga, Tennessee, is as follows.

Hospital	Avg. Net Revenue Per I/P Admission
Erlanger Medical Center	$ 10,579
Memorial Hospital	$ 10,968
Parkridge Medical Center	$ 15,503

Notes
(1) Information derived from Tennessee Joint Annual Reports for CY 2013.

While offering more complex services and capabilities, Erlanger has net revenue per inpatient admission comparable to other large area hospitals. *Erlanger Medical Center* is economically efficient, while incurring higher costs by offering more complex services including the only Level I trauma center, the only life-flight helicopter service, the only children's hospital, and the only Level III neonatal care in southeast Tennessee.

8. Discuss how financial viability will be ensured within two (2) years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

Response

In addition to high utilization, we have a need to perform MRI scans with newer technology for patients that require higher resolution imaging. The newer technology of 3.0 Tesla is becoming the standard of care in imaging such as Orthopedics, Neurology and Pediatrics. Currently, patients which require this type of imaging are being referred outside the *Erlanger* system of care. In 2013 we referred a total of 759 patients that required 3.0 Tesla imaging.

EMC seeks to acquire the Tesla 3.0 MRI unit in order to stay abreast of changing technology for imaging services. Also, we anticipate that this unit will handle some of the imaging that our other Tesla 1.5 MRI units have been handling. As may be seen from the *Projected Data Chart*, this project will be financially viable with the projected volumes of 2,350 procedures in year 1 and 2,975 procedures in year 2.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

Response

Erlanger Medical Center, as a member facility of *Erlanger Health System*, currently participates in the following Federal / State programs.

Federal	Medicare
State	BlueCare TennCare Select United Healthcare Community Plan *(Children's Medical Services under age 21 & High Risk Maternity Only)* AmeriGroup Community Care

Anticipated revenue (gross charges) from Federal and State sources during year 1 of the project is as follows.

Medicare	$ 2,640,828
TennCare	$ 413,165
	$ 3,053,993

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

Response

Copies of the following financial statements for *Erlanger Health System* are attached to this CON application.

Interim Balance Sheet & Income Statement	May 31, 2014
Audited Financial Statements	June 30, 2013

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to,

A. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If developments of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

Response

The proposed Tesla MRI unit will fill an essential gap in diagnostic capability in a number of service lines at *EMC* including Orthopedics, Neurology and Pediatrics. In these services, *EMC* already provides clinical leadership that is recognized in the region and beyond. For example, in neurosciences, the stroke program at *EMC* is recognized as one of the leading programs of its kind in the nation. The volume of patients served places it at the top of the list nationally. Further, *EMC* recently implemented an Epilepsy monitoring unit which will utilize the Tesla 3.0 MRI unit.

Erlanger seeks to acquire another MRI unit so as to be cost effective. The reasons for acquiring a 3.0 Tesla MRI unit are that the technology is, 1.) becoming the standard of care in some medical specialties such as Orthopedics; 2.) *EMC's* other 3 MRI units are over capacity and unable to keep up with demand for this imaging service, 3.) patient schedules are delayed and length of stay is increased by our high utilization, and 4.) *EMC's* mission to provide the appropriate level of service to low income and vulnerable populations will be further enhanced. The broad

healthcare system, and *EMC* specifically, will achieve economic efficiencies from the acquisition of a Tesla 3.0 MRI unit.

As *the* safety net hospital in Southeast Tennessee, it is vital that *EMC* enhance and update its facilities to provide the best imaging services available for the communities we serve. As an academic medical center affiliated with the University of Tennessee College of Medicine, which is co-located on the *Erlanger* campus, *EMC* seeks to provide appropriate facilities so as to enhance the training and education of medical residents and fellows as well as other health professionals. Updating facilities also means planning for tomorrow with regard to MRI services for the regional service area, ensuring that the needs of the uninsured and/or low income population are being met.

B. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

Response

This project consists of renovation of existing space on the *EMC* campus, no new construction is involved with this project.

Erlanger has postponed acquisition of a Tesla 3.0 MRI unit. The newer technology of 3.0 Tesla is becoming the standard of care in imaging for medical specialties such as Orthopedics, Neurology and Pediatrics. Currently, patients which require this type of imaging are being referred outside the *Erlanger* system of care. In 2013 we referred a total of 759 patients that required 3.0 Tesla imaging. As *the* safety net hospital in Southeast Tennessee, it is vital that *EMC* enhance and update its facilities to provide the best imaging services available for the communities we serve.

As an academic medical center affiliated with the University of Tennessee College of Medicine, which is co-located on the *Erlanger* campus, *EMC* seeks to provide

appropriate facilities so as to enhance the training and education of medical residents and fellows as well as other health professionals. Updating facilities also means planning for tomorrow with regard to MRI services for the regional service area, ensuring that the needs of the uninsured and/or low income population are being met.

(III.) *CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE*

1. **List all health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.**

Response

The most significant relationship between this proposal and the existing healthcare system is that it will be part of an existing health system and enhance *Erlanger Health System's* ability to integrate its services within the regional service area as the safety net provider, trauma center and region's only academic medical center.

By providing these services regardless of a patient's ability to pay, the regional healthcare delivery system is positively impacted by the services envisioned in the instant application.

The applicant currently has transfer arrangements with the following hospitals which are owned by *Erlanger Health System*.

-- Erlanger North Hospital
-- T. C. Thompson Children's Hospital
-- Erlanger East Hospital
-- Erlanger Bledsoe Hospital

Further, Erlanger currently has patient transfer agreements in place with more than 90 hospitals and other providers in the four (4) state area. These providers refer patients to Erlanger because of the depth and breadth

of its programs and services. A copy of the list of transfer agreements is attached to this CON application.

2. Describe the positive and / or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

Response

The effects of this proposal will be positive for the healthcare system because it will deliver the most appropriate level of care for those who are in need of service regardless of ability to pay, at a generally lower cost. By providing the Tesla 3.0 MRI service, the regional healthcare delivery system is positively impacted by serving as the "safety net" for those who are otherwise in need of this highly specialized service.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTE's for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the *Tennessee Dept. Of Labor & Workforce Development* and/or other documented sources.

Response

Clinical staffing for the Tesla 3.0 MRI service is anticipated to be 4.0 FTE's. The mid-point on Erlanger's pay scale for these positions will be $ 26.31 and the mid-point average hourly rate for the Chattanooga area is $ $ 29.52.

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Dept. Of Health, the Dept. Of Mental Health & Developmental Disabilities, and/or the Division of Mental Retardation Services

licensing requirements.

Response

The human resources required will be approached with a proactive recruitment action plan. Historically, *Erlanger* has met staffing requirements by utilizing a variety of methods. Thus, our approach to fulfill the staffing plan for the Tesla 3.0 MRI service will consist of a proactive plan of marketing, screening, hiring, and training.

The Human Resources Department at *Erlanger* will work closely with managers in the transition. The specifics will be based on the needs of the organization and aligned with the strategic initiative of the new Tesla 3.0 MRI service. *Erlanger* has actively been involved in the WorkForce Development movement on several different levels within the Chattanooga area and statewide. Current vacancy rates are below state and national averages.

Erlanger Health System participates with numerous schools that provide advanced training in the areas of nursing and allied health. Therefore, *Erlanger* expects no difficulty in recruitment of required staff given it's role as an academic medical center and it's affiliations with colleges and universities offering allied health and related training programs.

5. **Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review *policies and programs, record keeping, and staff education*.**

Response

The Applicant has reviewed and intends to comply with all licensing and certification requirements imposed by applicable statutes and regulations.

6. **Discuss your health care institution's participation in the training of students in the areas of medicine,**

nursing, social work, etc. (e.g., internships, residencies, etc.).

Response

Erlanger Health System, as the region's only academic medical center, has established strong long term relationships with the region's colleges, universities and clinical programs. *Erlanger* provides clinical sites for internships and rotation programs in nursing, radiology, respiratory, pharmacy and surgery technology, to name a few.

A number of regional universities offer Bachelor degree programs in nursing and physical therapy. *Erlanger* works closely with the University of Tennessee at Chattanooga to assist nurses transitioning from RN to BSN. Erlanger provides a teaching environment for staff as well with various on-the-job training opportunities (ex: CT for Radiologic Technologist, Certification for LPNs). Locally, two year degrees are available in many clinical allied health areas with additional programs offering advanced technical training in Radiological Imaging such as Nuclear Medicine, Diagnostic Ultrasonography, etc. *Erlanger Health System* participates with numerous schools that provide advanced training in the areas of nursing and allied health.

Erlanger has established strong long term relationships with the region's colleges, universities and clinical programs. Erlanger provides clinical sites for internships and rotation programs in nursing, radiology, respiratory care and pharmacy, to name a few. A number of regional universities offer Bachelor degree programs in nursing and physical therapy. Locally, two year degrees are available in many clinical allied health areas with additional programs offering advanced technical training in Radiological Imaging such as Nuclear Medicine and Diagnostic Ultrasonography.

The *University of Tennessee - College of Medicine* is co-located at Erlanger and includes training of senior medical students on clinical rotation as well as graduate medical education for training of residents and advanced fellowships in various medical specialties, including surgical specialties, as outlined below.

Residency Programs

- Emergency Medicine
- Family Medicine
- Internal Medicine
- Obstetrics & Gynecology
- Orthopedic Surgery
- Pediatrics
- Plastic Surgery
- Surgery
- Urology (beginning 2015)
- Transitional Year

Fellowship Programs

- Geriatrics
- Hospice & Palliative Care
- Orthopedic Surgery - Traumatology
- Surgical Critical Care
- Vascular Surgery
- Colon & Rectal Surgery
- Emergency Medicine
- Minimally Invasive Gynecologic Surgery
- Neuro-Interventional Surgery
- Ultrasound
- Cardiology (under development)
- Gastroenterology (under development)

Erlanger Health System participates with numerous schools that provide advanced training in the areas of nursing and allied health.

7. (a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Dept. Of Health, the Dept. Of Mental Health & Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.

Response

The Applicant has reviewed and intends to comply with all licensing and certification requirements imposed by applicable statutes and regulations.

(b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and / or accreditation.

Licensure: State of Tennessee, Dept. of Health

Accreditation: Joint Commission on Accreditation of Healthcare Organizations

If an existing institution, please describe the Current standing with any licensing, certifying, or accrediting agency or commission. Provide a copy of the current license of the facility.

Response

Erlanger Health System continuously strives to comply with applicable regulations and make needed changes where deficiencies may arise to ensure full compliance. A copy of the current license from the Tennessee Dept. of Health is attached to this CON application. Further, a copy of the most recent *Letter Of Accreditation* from *The Joint Commission* is attached to this CON application.

(c) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

Response

A copy of the most recent licensure/certification inspection report with an approved plan of correction is attached to this CON application.

8. Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5 % ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

Response

*** Not Applicable. ***

9. Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5 % ownership interest in the project.

Response

*** Not Applicable. ***

10. If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services And Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.

Response

Applicant will provide the *Health Services And Development Agency* with appropriate information in consideration of this CON application.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of publication of the letter of intent.

Attached is a copy of the *Letter Of Intent* which was filed with the *Tennessee Health Services & Development Agency* on September 10, 2014. The original publication affidavit is also attached.

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for cause shown. Subsequent to granting a Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**

   Response

   The Project Completion Forecast Chart has been completed and appears on the following page.

2. **If the response to the preceding question indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph, please state below any request for an extended schedule and document the "good cause" for such an extension.**

   Response

   *** Not Applicable. ***

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision Date, as published in Rule 68-11-1609(c): Dec. 17, 2014

Assuming the CON approval becomes the final Agency action on that date; indicate the number of days from the above agency decision date to each phase of the completion forecast.

PHASE		Days Required	Anticipated Date (MONTH / YEAR)
1.	Architectural and engineering contract signed.	5	Dec, 2014
2.	Construction documents approved by the *Tennessee Dept. Of Health.*	20	Jan, 2015
3.	Construction contract signed.	10	Feb, 2015
4.	Building permit secured.	5	Feb, 2015
5.	Site preparation completed.	15	Feb, 2015
6.	Building construction commenced.	5	Feb, 2015
7.	Construction 40 % complete.	65	Apr, 2015
8.	Construction 80 % complete.	65	Jun, 2015
9.	Construction 100 % complete (approved for occupancy.	35	Aug, 2015
10.	*Issuance of license.	15	Aug, 2015
11.	*Initiation of service.	5	Sep, 2015
12.	Final Architectural Certification Of Payment.	30	Oct, 2015
13.	Final Project Report Form (HF0055).	30	Nov, 2015

(*) For projects that do NOT involve construction or renovation, please complete items 10 and 11 only.

NOTE – If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

A F F I D A V I T

STATE OF TENNESSEE

COUNTY OF HAMILTON

Joseph M. Winick, being first duly sworn, says that he / she is the applicant named in this application or his / her / it's lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Agency Rules, and T.C.A. § 68-11-1601, *et seq*, and that the responses to this application or any other questions deemed appropriate by the Tennessee Health Services & Development Agency are true and complete.

SIGNATURE

SWORN to and subscribed before me this 11th of September (Month), 2014 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

SHELIA HALL
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

Shelia Hall
NOTARY PUBLIC

My commission expires June 9 (Month / Day), 2018.

TABLE OF ATTACHMENTS

** NOTE - The attachments are paginated and the page number begins with "A". The page number appears in the upper right hand corner of the page.

ATTACHMENTS

LETTER OF INTENT
TENNESSEE HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Chattanooga Times Free Press, which is a newspaper of general circulation in Hamilton County, Tennessee, on or before September 10, 2014, for one day.

This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. §68-11-1601 *et. seq.*, and the Rules of the Health Services & Development Agency, that Erlanger Medical Center, owned by the Chattanooga-Hamilton County Hospital Authority D/B/A Erlanger Health System, with an ownership type of governmental, and to be managed by itself, intends to file an application for a Certificate of Need for a Magnetic Resonance Imaging (Tesla 3.0) Scanner. No other health care services will be initiated or discontinued.

The facility and equipment will be located in Erlanger Medical Center, at 975 East 3rd Street, Chattanooga, Hamilton County, Tennessee 37403. The total project cost is estimated to be $ 4,597,711.00.

The anticipated date of filing the application is September 15, 2014.

The contact person for this project is Joseph M. Winick, Sr. Vice President, Erlanger Health System, 975 East 3rd Street, Chattanooga, Tennessee 37403, and by phone at (423) 778-7274.

Joseph M. Winick	September 5, 2014	Joseph.Winick@erlanger.org
	Date:	E-Mail:

The Letter Of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services & Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

The published Letter Of Intent must contain the following statement pursuant to T.C.A. §68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

SEP 12 '14 AM 10:12

Place Your Classified, www.timesfreepress.com

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. §68-11-1601 et. seq., and the Rules of the Health Services & Development Agency, that Erlanger Medical Center, owned by the Chattanooga-Hamilton County Hospital Authority D/B/A Erlanger Health System, with an ownership type of governmental, and to be managed by itself, intends to file an application for a Certificate of Need for a Magnetic Resonance Imaging (Tesla 3.0) Scanner. No other health care services will be initiated or discontinued.

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Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services & Development Agency
Andrew Jackson Building
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Nashville, Tennessee 37243

Pursuant to T.C.A. § 68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate Of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

37751967

2788719
ERLANGER STRATEGIC
STRATEGIC PL
STRATEGIC PLANNING DEPT.

STATE OF TENNESSEE
HAMILTON COUNTY

Before me personally appeared Pam Saynes who being duly sworn, that she is the Legal Sales Representative of the "CHATTANOOGA TIMES FREE PRESS" and that the Legal Ad of which the attached is a true copy, has been published in the above said Newspaper and on the website on the following dates, to-wit:

September 10, 2014

And that there is due or has been paid the "CHATTANOOGA TIMES FREE PRESS" for publication of such notice the sum of Net $672.40 Dollars. (Includes $10.00 Affidavit Charge).

Pam Saynes

Sworn to and subscribed before me, this 10th day of September 2014.

MARYLU McDONALD
STATE OF TENNESSEE
NOTARY PUBLIC
HAMILTON COUNTY

Marylu McDonald

My Commission Expires 7/20/2016

Chattanooga Times Free Press

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37751967

State of Tennessee

EHS Enabling Legislation

Department of State

To all to whom these Presents shall come, Greeting:

I Gentry Crowell, Secretary of State of the State of Tennessee do hereby certify that the annexed is a true copy of

PRIVATE CHAPTER NO. 125

SENATE BILL NO. 1499

PRIVATE ACTS OF 1977

the original of which is now on file and a matter of record in this office.

In Testimony Whereof, I have hereunto subscribed my Official Signature and by order of the Governor affixed the Great Seal of the State of Tennessee at the Department in the City of Nashville, this 13th day of June

A.D. 19 77

Gentry Crowell

PRIVATE CHAPTER NO 125

SENATE BILL NO. 1499

By Albright, Ortwein

Substituted for: House Bill No. 1514

By Robinson (Hamilton)

AN ACT To amend Chapter 297 of the 1976 Private Acts of Tennessee entitled "AN ACT To create a Governmental Hospital Authority to own and operate Baroness Erlanger Hospital, T. C. Thompson Children's Hospital and other related facilities and provide for the establishment and organization of a Board of Trustees for the operation thereof," relative to the Board of Trustees of said Hospital Authority and the powers and duties thereof, to the issuance of bonds and other obligations by the authority and the securing thereof, to the Financial Review Commission with respect to the authority and the duties and powers thereof, and to other provisions with respect to the duties and obligations of the authority, and validating and reenacting said Chapter No. 297 and ratifying all acts of the Board of Trustees of the authority.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Chapter 297 of the Private Acts of 1976 is amended by amending Section 1 thereof to read as follows:

"SECTION 1. A governmental Hospital Authority to be known as the Chattanooga-Hamilton County Hospital Authority, is hereby created and established for and on behalf of Hamilton County, Tennessee, for the purpose of performing a governmental function by operating Baroness Erlanger Hospital and T. C. Thompson Children's Hospital and such other similar or associated hospitals and existing health centers deemed appropriate to be operated by said authority as sole operator for the purpose of providing health care facilities and programs for the residents of Hamilton County, Tennessee."

SECTION 2. Chapter 297 of the Private Acts of 1976 is amended by deleting the first paragraph of Section 2 thereof and by substituting for such paragraph two new paragraphs to read as follows:

"SECTION 2. The Hospital Authority shall be operated upon the tracts and parcels of real property owned jointly by Hamilton County and the City of Chattanooga, Tennessee, and on which are situated the Baroness Erlanger Hospital and the T. C. Thompson Children's Hospital or upon any other real property acquired by the authority through gift and purchase. The city and the county are authorized and directed to convey and assign all real property constituting the Baroness Erlanger Hospital and the T. C. Thompson Children's Hospital to the authority. The city and the county are also authorized to convey and assign all personal property constituting the Baroness Erlanger Hospital and the T. C. Thompson Children's Hospital to the authority.

"In the event the authority shall at any time cease to exist as the operator of Baroness Erlanger Hospital, T. C. Thompson Children's Hospital and such other similar or associated hospitals and existing health centers deemed appropriate to be operated by the authority as sole operator, the real estate which was owned on August 5, 1976, by the county and the city and conveyed to the authority by the county and the city, shall revert in fee simple to the county, subject to such encumbrances as may be on said property at the time of reversion; provided, however, that the city shall have an option to require transfer to it of the title to the same proportion of such real estate as was owned by the city on such date, subject to such encumbrances on that portion of the real estate.

"If the authority shall at any time cease to use any such parcel or parcels of said real estate for hospital or related purposes for a period of two (2) years, then the county and the city shall have the option to require transfer to them of title to such parcel or parcels in fee simple, subject to such encumbrances as may be on said property at the time of such transfer of title, in the same proportion as such parcel or parcels were previously owned by the county and the city. In the event that either the county or the city shall elect not to exercise its option with respect to any such parcel or parcels of real estate, then the other of them shall have the option to require transfer to it of the entire parcel or parcels of real estate in question. In the event that neither the county nor the city decides that they wish to exercise said option, then the authority shall have the right to dispose of such property in whatever manner it deems appropriate."

SECTION 3. Chapter 297 of the Private Acts of 1976 is amended by amending Section 3 thereof to read as follows:

"SECTION 3. Said Hospital Authority shall be operated and controlled by a Board of Trustees consisting of eleven (11) members who shall serve without compensation but who shall be indemnified by the authority for any liability they might incur while acting in such capacity other than from culpable negligence. The original members of the Board of Trustees and their respective terms of office are declared to be those

individuals whose names are set out below, and upon expiration of such terms the members of the Board of Trustees shall be appointed by the county judge of the county, the mayor of the city, the chancellors of the chancery courts, and the legislative delegation for four (4) year terms as provided in the next succeeding paragraph hereof. The following are confirmed as the original members of the Board of Trustees and shall hold office for terms ending as follows (or until their successors are appointed):

Name of Trustee	Successor to be Appointed by	Term of Office Expires
David P. McCallie, M.D.	Mayor	11-1-80
Mrs. Vi Ketchersid	County Judge	11-1-80
Stan Guthrie	Chancellors	11-1-80
Harry W. McKeldin, Jr.	Mayor	11-1-79
Sobert Brewer, Jr.	County Judge	11-1-79
Don J. Russell, M.D.	Mayor and County Judge (with approval of medical society)	11-1-79
J. E. Lawrence	Mayor	11-1-78
John C. Cantrell	County Judge	11-1-78
Claude Ramsey	Legislative Delegation	11-1-78
Charles Griffin	Mayor	11-1-77
Forrest Cate	County Judge	11-1-77

"The method of appointment of the members of the Board of Trustees after the expiration of the terms of the original members of such board shall be as follows: The mayor of the city shall appoint four (4) trustees, with the approval of a majority of the members of the Board of Commissioners. The county judge of the county shall appoint four (4) trustees, with the approval of a majority of the members of the county council. Said mayor and county judge shall jointly appoint one (1) trustee with the approval of the president of the Chattanooga-Hamilton County Medical Society, Inc., acting with the approval of a majority of the House of Delegates of said society, and with the approval of a majority of the members, respectively, of the Board of Commissioners and of the county council. The chancellors of chancery court shall jointly appoint one (1) trustee. The legislative delegation shall by a majority vote appoint one (1) trustee.

"Upon the expiration of the term of office of any trustee, his successor shall be appointed for a term of four (4) years by the authority appointing the trustee whose term has expired. The original trustees, for all purposes of this section, shall be considered to have been appointed by the mayor, the county judge, the chancellors and/or the legislative delegation as indicated in the above tabulation.

"All such appointments to the Board of Trustees as provided herein shall be made without regard to religious preference, race, sex or national origin, and in the making of appointments due consideration shall be given to making said Board of Trustees representative, as nearly as may be practicable, of all residents of the city and county, including the various racial groups therein.

"Any member so appointed to the Board of Trustees may, for reasonable cause, be removed from his or her office in the same manner and by the same authority as such member was appointed to the office; provided that such removal shall be preceded by a full hearing and adequate notice of such hearing. 'Reasonable cause' shall include, but shall not be limited to, misconduct in office, failure to perform duties prescribed by this act or other applicable law, or failure to diligently pursue the objectives for which the authority was created.

"Vacancies on the Board of Trustees caused by any reason whatsoever, shall be filled by appointment of the authority who appointed the trustee vacating the office, but without the necessity of approval otherwise herein required. A trustee so appointed shall hold office for the remainder of the term of the trustee vacating the office.

"A member of the Board of Trustees may serve as such trustee for not more than eight (8) consecutive years, excluding any previous service as a member of the Board of Trustees of Baroness Erlanger Hospital and/or T. C. Thompson Children's Hospital."

The occupancy of their respective offices by the present members of the Board of Trustees (being those individuals enumerated in amended Section 3 above) is hereby ratified and confirmed.

SECTION 4. Chapter 297 of the Private Acts of 1976 is amended by repealing Section 4 thereof and substituting therefor a new Section 4 to read as follows:

"SECTION 4. Whenever used in this act, unless a different meaning clearly appears from the context, the following terms whether used in the singular or the plural shall be given the following respective interpretations:

'Authority' or 'Hospital Authority' means the Chattanooga-Hamilton County Hospital Authority as created by this act.

'Board of Commissioners' means the Board of Commissioners of the city.

'Board of Trustees' means the Board of Trustees of the authority as provided for in this act.

'Bonds' means bonds of the authority authorized to be issued by this act. 'Advance refunding bonds' means bonds issued for the purpose of refunding outstanding bonds which will neither mature by their terms nor be subject to and called for redemption within a period of 30 days following the date of issuance of said advance refunding bonds.

'Chancellors' means the Chancellors of the Chancery Courts of Hamilton County, Tennessee.

'Chief Executive Officer' means, as the context requires, the president of the authority, the mayor of the city, and the county judge of the county.

'City' means the City of Chattanooga, Tennessee.

'County' or 'Hamilton County' means Hamilton County, Tennessee.

'County Council' means the county council of the county.

'County Judge' means the county judge or such other chief executive officer of the county as may be created by subsequent law.

'Financial Review Committee' means the Financial Review Committee provided for in this act.

'Hamilton County Sales Tax Agreement' means the agreement between the city and the county, dated March 23, 1966.

'Legislative Delegation' means the Hamilton County delegation to the Legislature of Tennessee, being the Senators and Representatives elected from those districts lying in whole or in part in the county.

'Mayor' means the mayor of the city or such other chief executive officer of the city as may be created by subsequent law.

'Notes' means notes of the authority authorized to be issued by this act. 'Short-Term Notes' means nonrenewable notes having a term no longer than three (3) years. 'Long-Term Notes' means renewable short-term notes and notes having a term longer than three (3) years.

'Project' or 'Facility' shall mean any one or combination of buildings, structures or facilities owned by the authority, including the site therefor and all machinery and equipment therein or necessary to the operation thereof, and shall include expressly the Baroness Erlanger Hospital and the T. C. Thompson Children's Hospital."

SECTION 5. Chapter 297 of the Private Acts of 1976 is amended by repealing Section 5 thereof and by renumbering Section 6 thereof as Section 5.

SECTION 6. Chapter 297 of the Private Acts of 1976 is amended by renumbering Section 7 thereof as Section 6 and by amending said renumbered Section 6 to read as follows:

"SECTION 6. The Board of Trustees shall be vested with the full, absolute and complete authority and responsibility for the complete operation, management, conduct and control of the business and affairs of the Hospital Authority herein created. This authority and responsibility shall include, but shall not be limited to, the establishment, promulgation and enforcement of the rules, regulations and policies of the authority, the granting of or the refusal of medical staff privileges, the upkeep and maintenance of all property, the administration of all financial affairs of the authority, including pledging of assets for expansion and improvement of facilities and any other necessary financial needs of the authority. The authority shall have, but shall not be limited to, the following powers together with all powers incidental thereto or necessary for the performance of those hereinafter stated: (1) to sue and be sued and to prosecute and defend, at law or in equity, in any court having jurisdiction of the subject matter and of the parties; (2) to have and use an official seal and to alter the same at pleasure; (3) to acquire, whether by purchase, construction, exchange, gift, lease, or otherwise, and to improve, maintain, extend, equip and furnish hospital and related facilities within the corporate limits of Hamilton County, including expressly, but without limitation, professional office buildings, ancillary residence facilities and data processing facilities, and including all real and personal properties which the Board of Trustees may deem necessary in connection therewith and regardless of whether or not any such facilities shall then be in existence; (4) to execute all contracts, agreements and other instruments with any person, partnership, corporation, federal, state, county or municipal government, including but not limited to the issuance of bonds, mortgages, notes and other forms of indebtedness, and contracts for the

management of hospital and clinic facilities (but no such management contract shall exceed two (2) years in length); (5) subject to the provisions of Section 2 hereof, to sell, lease, exchange, donate, and convey any or all of its properties whenever its Board of Trustees shall find any such action to be in furtherance of the purposes for which the authority was created; (6) to borrow money and issue its bonds and notes for the purpose of carrying out any of its powers; (7) as security for the payment of the principal of and interest on any bonds and notes so issued and any agreements made in connection therewith, to mortgage and pledge any or all of its facilities or any part or parts thereof, whether then owned or thereafter acquired, and to pledge all or any portion of the revenues and receipts therefrom or from any thereof; (8) to employ and pay compensation to such employees, and agents, including attorneys, accountants, engineers, architects and financial consultants, as the Board of Trustees shall deem necessary for the business of the authority; and (9) to establish bylaws and make all rules and regulations not inconsistent with the provisions of this act, deemed expedient for the management of the authority's affairs.

"No contract, except for personal services or lease obligations, involving an expenditure exceeding one thousand dollars ($1,000.00), nor several proposed contracts aggregating more than one thousand dollars ($1,000.00), for the same general work or kind of work, supplies or equipment, shall be awarded until after at least one advertisement in some newspaper of general circulation published in the county at least ten (10) days before such contract is awarded or supplies purchased, and then only to the lowest and best bidder. Said bids shall be sealed and filed with the president or his designee, who shall publicly open them on the date specified and not prior thereto. No entire project or purchase involving the same type of work, equipment or supplies shall be split into small contracts. Nothing in this paragraph shall be construed to apply to the issuance of bonds or notes by the authority.

"Purchases and contracts involving an expenditure of not more than one thousand dollars ($1,000.00) shall be made in conformity with the rules and regulations adopted by the Board of Trustees.

"The authority shall prescribe reasonable rates, fees and charges for the services and facilities furnished by the authority and shall revise such rates, fees and charges from time to time so as to produce revenue at least sufficient to pay the principal of and interest on all bonds and other obligations issued by the authority, including reserves therefor, and to pay the cost of maintaining and operating its facilities."

SECTION 7. Chapter 297 of the Private Acts of 1976 is amended by the addition of a new Section 7 thereto to read as follows:

"SECTION 7. Except as herein otherwise expressly provided, all bonds issued by the authority shall be payable solely out of and secured by a pledge of all or any portion of the revenues and receipts derived from the authority's projects or of any thereof as may be designated in the proceedings of the Board of Trustees under which such obligations shall be authorized to be issued and may be secured by a mortgage or deed of trust covering all or any part of the projects from which the revenues and receipts so pledged may be derived, as such projects may thereafter be extended or enlarged; provided, that notes issued in anticipation of the issuance of bonds may be retired out of the proceeds of such bonds. The proceedings under which the bonds are authorized and any such mortgage or deed of trust may contain agreements and provisions respecting the maintenance of the facilities covered thereby, the establishment of rates, fees and charges for the services and facilities furnished by the authority, the creation and maintenance of special funds from the revenues of the authority and the rights and remedies available in the event of default, all as the Board of Trustees shall determine advisable and not in conflict with the provisions of this act. Each pledge, mortgage and deed of trust made for the benefit or security of any bonds of the authority shall continue in effect until the principal of and interest on the bonds for the benefit of which the same were made shall have been fully paid. In the event of default in such payment or in any agreement of the authority made as a part of the contract under which the bonds were issued, whether contained in the proceedings authorizing the bonds or in any mortgage or deed of trust executed as security therefor, such payment or agreement may be enforced by suit, mandamus, the appointing of a receiver in equity or by foreclosure of any such mortgage or deed of trust, or any one or more of such remedies.

"Such bonds may be executed and delivered by the authority at any time and from time to time, may be in such form and denominations and of such terms and maturities, may be subject to redemption prior to maturity either with or without premium, may be in fully registered form or in bearer form registrable either as to principal or interest or both, may bear such conversion privileges and be payable in such installments and at such time or times not exceeding forty (40) years from the date thereof, may be payable at such place or places whether within or without the State of Tennessee, may bear interest at such rate or rates payable at such time or times and at such place or places and evidenced in such manner, may be executed by such officers of the authority, and may contain such provisions not inconsistent herewith, all as shall be provided in the proceedings of the Board of Trustees whereunder the bonds shall be authorized to be issued. Any bonds of the authority may be sold at public or private sale for such price and in such manner and from time to time as may be determined by the Board of Trustees to be most advantageous, and the authority may pay all expenses, premiums and commissions which its Board of Trustees may deem necessary or advantageous in connection with the issuance thereof.

"Proceeds of bonds and notes issued by the authority may be used for the purpose of constructing, acquiring, reconstructing, improving, equipping, furnishing, bettering, or extending any project or projects, including the payment of interest on the bonds during construction of any such project and for six (6) months after the estimated date of completion, the payment of engineering, fiscal, architectural, bond insurance and legal expenses incurred in connection with such project and the issuance of the bonds, and the establishment of a reasonable reserve fund for the payment of principal of and interest on such bonds in the event of a deficiency in the revenues and receipts available for such payment. Any bonds and long-term notes shall, except as herein otherwise expressly provided, be issued for capital expenditures and none of the proceeds shall be used for operational expenditures or routine maintenance needs.

"Except as hereinafter in this paragraph provided, the amount of bonds and notes of the authority which may be issued at any time, together with any bonds and notes of the authority then outstanding, shall not exceed an amount equal to ninety percent (90%) of the sum of the value of the existing plant, property and equipment of the authority at the time of issuance of such bonds plus the contract price of the improvements to be constructed, acquired and installed from the proceeds of such bonds, less (1) the principal amount outstanding, if any, of such bonds as may have been issued by the county for the expansion, remodeling, repairing, equipping, and/or construction of all or any part of Baroness Erlanger Hospital and/or T. C. Thompson Children's Hospital, and (2) the amount, if any, of any unfunded portion of the employees' pension fund of Baroness Erlanger Hospital and/or T. C. Thompson Children's Hospital. Plant, property and equipment for the purpose of the preceding sentence shall be stated at market value as determined by a professional appraiser to be selected by the Financial Review Committee. A certificate of such professional appraiser with respect to the value of such plant, property and equipment, a certificate of the county judge of the county with respect to the amount of outstanding bonds of the county for such hospital purposes, and a certificate of the chief executive officer of the authority with respect to the unfunded portion of such employees' pension fund shall each be conclusive for the purposes of determining the amount of bonds and notes which may be issued pursuant to this paragraph. The limitations expressed in this paragraph shall not apply to the issuance of advance refunding bonds.

"The Board of Trustees shall direct in the proceedings authorizing the issuance of any bonds of the authority that there shall be set aside and appropriated as a reserve for the payment of principal and interest on said bonds an amount not less than the required amount of principal and interest on the bonds falling due during the 12 month period next succeeding the date of issuance of the bonds."

"Any bonds or notes of the authority at any time outstanding may at any time and from time to time be refunded by the authority by the issuance of its refunding bonds in such amount as the Board of Trustees may deem necessary, but not exceeding the sum of the following: (a) the principal amount of the obligations being refinanced; (b) applicable redemption premiums thereon; (c) unpaid interest on such obligations to the date of delivery or exchange of the refunding bonds; (d) in the event the proceeds from the sale of the refunding bonds are to be deposited in trust

as hereinafter provided, interest to accrue on such obligations from the date of delivery to the first or any subsequent available redemption date or dates selected, in its discretion, by the Board of Trustees, or to the date or dates of maturity, whichever shall be determined by the Board of Trustees to be most advantageous or necessary to the authority; and (e) expenses, premiums and commissions of the authority, including bond discount, deemed by the Board of Trustees to be necessary for the issuance of the refunding bonds. A determination by the Board of Trustees that any refinancing is advantageous or necessary to the authority, or that any of the amounts provided in the preceding sentence should be included in such refinancing, or that any of the obligations to be refinanced should be called for redemption on the first or any subsequent available redemption date or permitted to remain outstanding until their respective dates of maturity, shall be conclusive.

"Any such refunding may be effected either by the exchange of the refunding bonds for the obligations to be refunded thereby with the consent of the holders of the obligations so to be refunded, or by sale of the refunding bonds and the application of the proceeds thereof to the payment of the obligations to be refunded thereby, in the manner herein provided.

"Prior to the issuance of the refunding bonds, the Board of Trustees shall cause notice of its intention to issue the refunding bonds, identifying the obligations proposed to be refunded and setting forth the estimated date of delivery of the refunding bonds, to be given to the holders of the outstanding obligations by publication of an appropriate notice one (1) time each in a newspaper having general circulation in Hamilton County and in a financial newspaper published in New York, New York, and having national circulation. As soon as practicable after the delivery of the refunding bonds, and whether or not any of the obligations to be refunded are to be called for redemption, the Board of Trustees shall cause notice of the issuance of the refunding bonds to be given in the manner provided in the preceding sentence.

"If any of the obligations to be refunded are to be called for redemption, the Board of Trustees shall cause notice of redemption to be given in the manner required by the proceedings authorizing such outstanding obligations.

"The principal proceeds from the sale of any refunding bonds shall be applied only as follows: either,

(a) to the immediate payment and retirement of the obligations being refunded; or

(b) to the extent not required for the immediate payment of the obligations being refunded then such proceeds shall be deposited in trust to provide for the payment and retirement of the obligations being refunded and to pay any expenses incurred in connection with such refunding, but provision may be made for the pledging and disposition of any surplus, including, without limitation, provision for the pledging of any such surplus to the payment of the principal of and interest on any issue or series of refunding bonds. Money in any such trust fund may be invested in direct obligations of, or obligations the timely payment of principal of and interest on which are fully guaranteed by the United States government, or obligations of any agency or instrumentality of the United States government, or in certificates of deposit issued by a bank or trust company located in the State of Tennessee if such certificates shall be secured by a pledge of any of said obligations having an aggregate market value, exclusive of accrued interest, equal at least to the principal amount of the certificates so secured. Nothing herein shall be construed as a limitation on the duration of any deposit in trust for the retirement of obligations being refunded but which shall not have matured and which shall not be presently redeemable or, if presently redeemable, shall not have been called for redemption."

SECTION 8. Chapter 297 of the Private Acts of 1976 is amended by adding at the end of the third paragraph of Section 9 thereof a new sentence to read as follows:

"A certificate by such actuary with respect to the currency of such required pension fund contributions shall be conclusive for the purpose of determining compliance by the authority with the provisions of this section."

SECTION 9. Chapter 297 of the Private Acts of 1976 is amended by adding a new sentence to the end of Section 10 thereof, said new sentence to read as follows:

"Notwithstanding the foregoing provisions of this section, nothing herein contained shall be construed as limiting any expenditures made by the authority for the payment of principal of and in-

terest on bonds or other obligations issued by the authority."

SECTION 10. Chapter 297 of the Private Acts of 1976 is amended by amending Section 11 thereof to read as follows:

"SECTION 11. A Financial Review Committee shall be created consisting of seven (7) members, one (1) of whom shall be Black. The membership shall be composed of the auditor of the city, the auditor of the county, and five (5) other persons who are residents of Hamilton County, three (3) of whom shall be appointed by the county judge with the approval of a majority vote of the county council and two (2) of whom shall be appointed by the mayor with the approval of a majority vote of the Board of Commissioners; provided, that if any members of such committee shall not have been so appointed within 90 days from the date of approval of this act by the county council of the county, such members shall thereupon be appointed by a majority vote of the members of the legislative delegation.

"The members of the committee shall serve without compensation. They shall be indemnified by the authority for any liability they might incur while acting in such capacity other than for culpable negligence. With the exception of the city auditor and the county auditor, the remaining members shall be initially appointed to staggered terms as follows: two (2) for terms of three (3) years; one (1) to be so appointed by the county judge and one (1) to be so appointed by the mayor; two (2) for terms of two (2) years; one (1) to be so appointed by the county judge and one (1) to be so appointed by the mayor; and one (1) to be so appointed by the county judge for a term of one (1) year. Thereafter, each appointee shall serve for a period of three (3) years and such appointee's successor shall be appointed in the same manner and by the same official who appointed the person whose term has expired. Any person appointed to fill a vacancy for any reason other than expiration of term of office shall be appointed to hold office for the remainder of the term of the member vacating the office. Said vacancy shall be filled in the same manner as the original appointment.

"The Financial Review Committee shall review the proposed issuance of bonds or long-term notes, to consider if the issuance of said obligations is within the fiscal ability of the authority based upon the appropriate preceding annual audits, monthly operating statements subsequent to the closing date of the most recent audit period included in the most recent annual audit, additional revenue projections reasonably anticipated as a result of the proposed capital expenditure (taking into account any probable revenue loss during replacement, if any), and any other data reasonably bearing upon the fiscal soundness of the issuance of such bonds or long-term notes. At such time or times as the Board of Trustees of the authority shall desire to authorize the issuance of bonds or long-term notes it shall first submit the proposal to issue such obligations to the Financial Review Committee, which committee shall file its advisory report thereon with the Board of Trustees within sixty (60) days after the receipt of such proposal. Upon the filing of such report with the Board of Trustees, or after sixty (60) days following the date of submission of such proposal to such committee, whichever is earlier, the Board of Trustees may proceed with the issuance of such bonds or long-term notes; provided, that the submission to the Financial Review Committee herein required shall not be necessary at any time if such committee has not then been validly appointed and is not in existence.

"The Financial Review Committee shall annually review the proposed budget prepared by the Board of Trustees and shall file its report thereon with the Board of Trustees and the County Council.

"All reports of the Financial Review Committee shall be made to the County Council of the county, the Board of Commissioners of the city and the Board of Trustees of the authority, and shall be considered by the respective governing bodies with which such reports are filed."

SECTION 11. Chapter 297 of the Private Acts of 1976 is amended by adding six new sections thereto to be numbered 17 to 22, inclusive, and to read as follows:

SECTION 17. Notwithstanding any other provision of this act the county shall have the option to purchase all real and personal property of the authority if either of the following shall have occurred:

(a) The authority shall have defaulted in the payment when due of principal or interest on any of its bonds or long-term notes then outstanding; or

(b) The authority shall have filed written notice with the county judge that it is the expectation of the Board of Trustees of the authority that the authority will so default in the payment of principal of or interest on any of its bonds or long-term notes then outstanding on the next succeeding date on which such principal or interest shall fall due.

"The purchase price in the event that the county shall elect to exercise any such option shall be an amount equal to the principal of and interest to maturity or the first call date, if any, whichever shall be earlier, together with any applicable premiums, on all bonds and long-term notes of the authority then outstanding, and the amount so received by the authority from the county shall be impressed with a trust in favor of the holders of such bonds and long-term notes and shall be used for the payment of principal of and interest and redemption premiums thereon and for no other purpose.

"Such purchase option of the county shall be superior to any right of foreclosure herein permitted, and any mortgage hereinafter granted by the authority shall recognize and be subject to such option to purchase.

"SECTION 18. The authority is hereby declared to be a public instrumentality acting on behalf of the county, but without the power of eminent domain, and in that connection to be fulfilling a public function, and the authority and all properties at any time owned by it and the income therefrom and all bonds or notes issued by the authority and the income therefrom shall be exempt from all taxation in the State of Tennessee. Also, for purposes of the Securities Law of 1955, compiled as Sections 48-1601 through 48-1648, Tennessee Code Annotated, and any amendment thereto or substitution therefor, bonds or notes issued by the authority shall be deemed to be securites issued by a public subdivision of the State of Tennessee.

"SECTION 19. The authority shall be a public nonprofit corporation and no part of its net earnings remaining after payment of its expenses shall inure to the benefit of any individual, firm or corporation.

"SECTION 20. Neither the county nor the city shall in any event be liable for the payment of the principal of or interest on any bonds or notes of the authority or for the performance of any pledge, mortgage, obligation or agreement of any kind whatsoever which may be undertaken by the authority, and none of the bonds or notes of the authority or any of its agreements or obligations shall be construed to constitute an indebtedness of either the county or the city within the meaning of any constitutional or statutory provision whatsoever.

"SECTION 21. Nothing contained in this act shall be construed to impair any contract rights which may have vested prior to the enactment of this act.

"SECTION 22. It is hereby declared that the purpose of this act is to facilitate adequate hospital facilities for the residents of the county. Bonds may be issued under this act without regard to the requirements, restrictions or procedural provisions contained in any other law."

SECTION 12. Chapter 297 of the Private Acts of 1976 is hereby in all respects ratified and confirmed and said act as herein amended is hereby reenacted by this General Assembly.

SECTION 13. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect any other provisions or application of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 14. This act shall have no effect unless it is approved by a two-thirds vote of the County Council of Hamilton County. Its approval or nonapproval shall be proclaimed by the presiding officer of the county council and certified by such officer to the Secretary of State.

SECTION 15. For the purpose of approving this act as provided in Section 14 it shall take effect on becoming law, the public welfare requiring it, but for all other purposes it shall be effective only upon being approved as provided in Section 14.

SENATE BILL NO. 1499

PASSED: May 19, 1977

SPEAKER OF THE SENATE

SPEAKER OF THE HOUSE OF REPRESENTATIVES

APPROVED this 28th day of May 19 77

GOVERNOR

4 September 2014

DH&W
ARCHITECTURE INTERIORS PLANNING

Mr. Gary Orrell, Construction Manager
Erlanger Health System
975 East Third Street
Chattanooga, TN

RE: Renovation for MRI Unit
Ground Floor – Medical Mall

Dear Mr. Orell:

I have attached a drawing titled "Schematic Plan" dated 4 September 2014. The budget indicating a construction cost of $1,030,203 is reasonable considering the complexity for this type of construction. Furthermore the scheduled completion of the work on 18 August 2015 includes reasonable time for all activities associated with this project.

It is our intent to design the new renovation meeting all known current building codes and follow all requirements for health facility construction.

Sincerely yours,

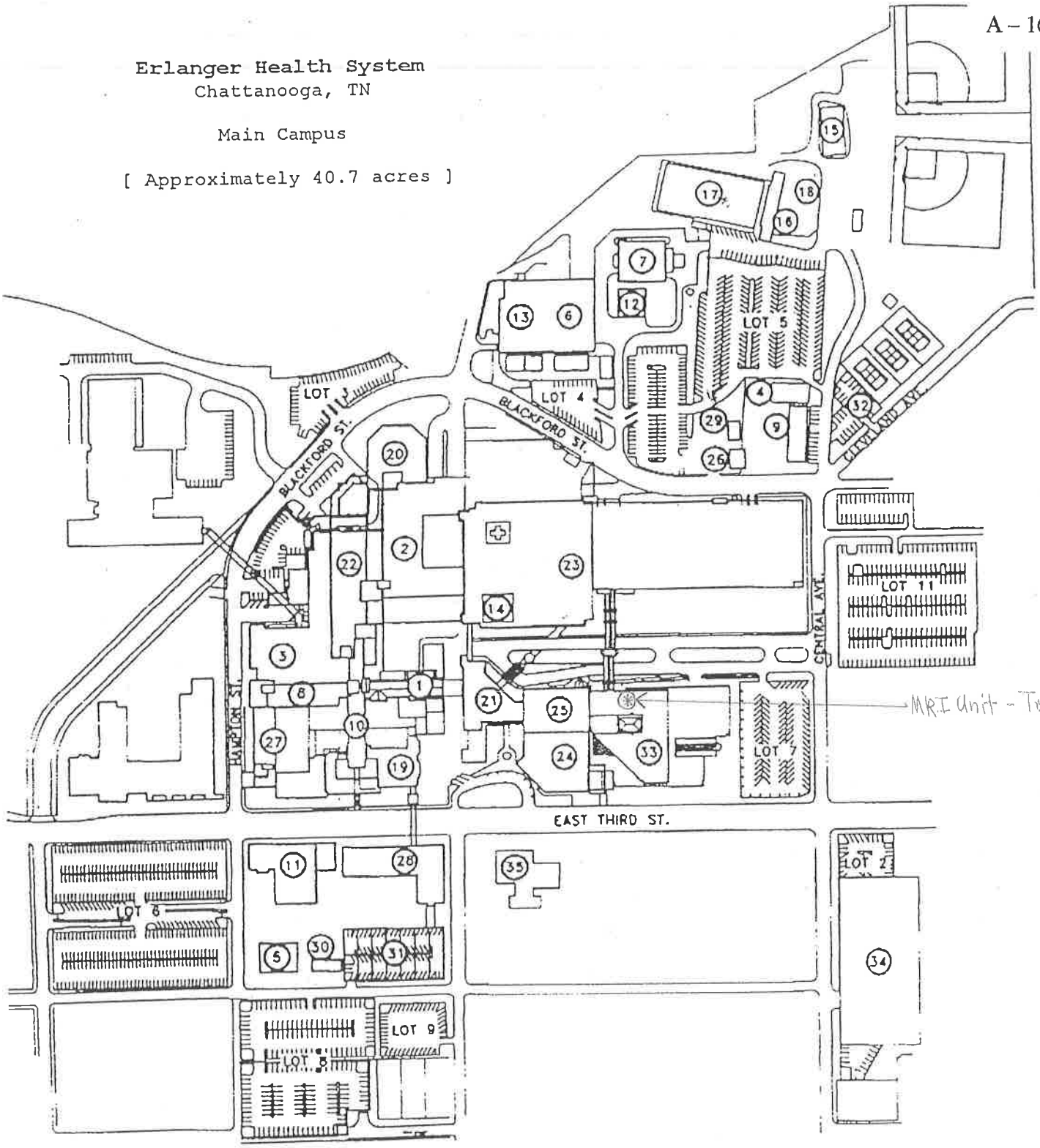
William H. Wilkerson

1001 Carter Street | Chattanooga, Tennessee 37402 | voice 423.266.4816 | fax 423.267.8830 | www.dhw-architects.com

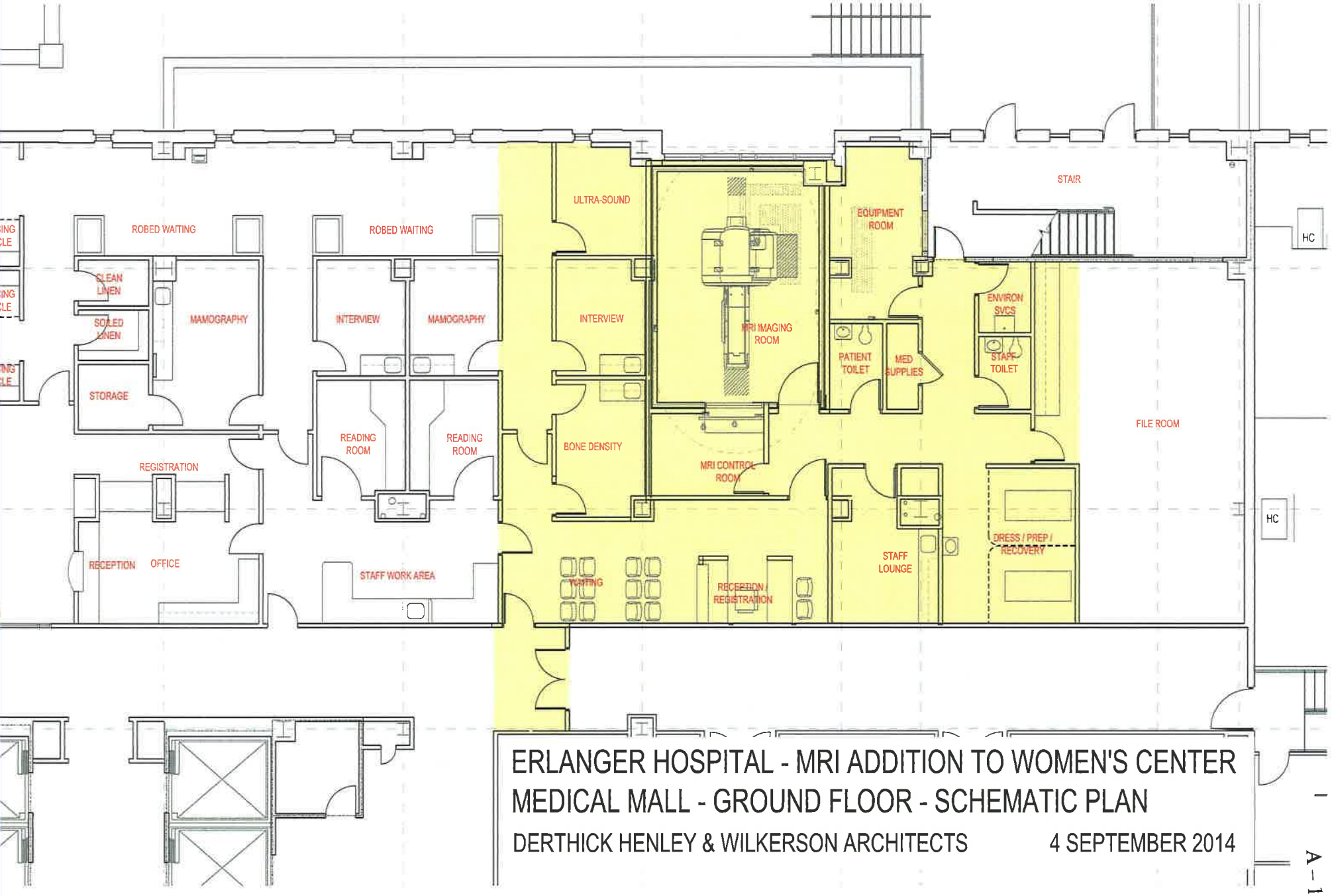
Erlanger Health System
Chattanooga, TN

Main Campus

[Approximately 40.7 acres]

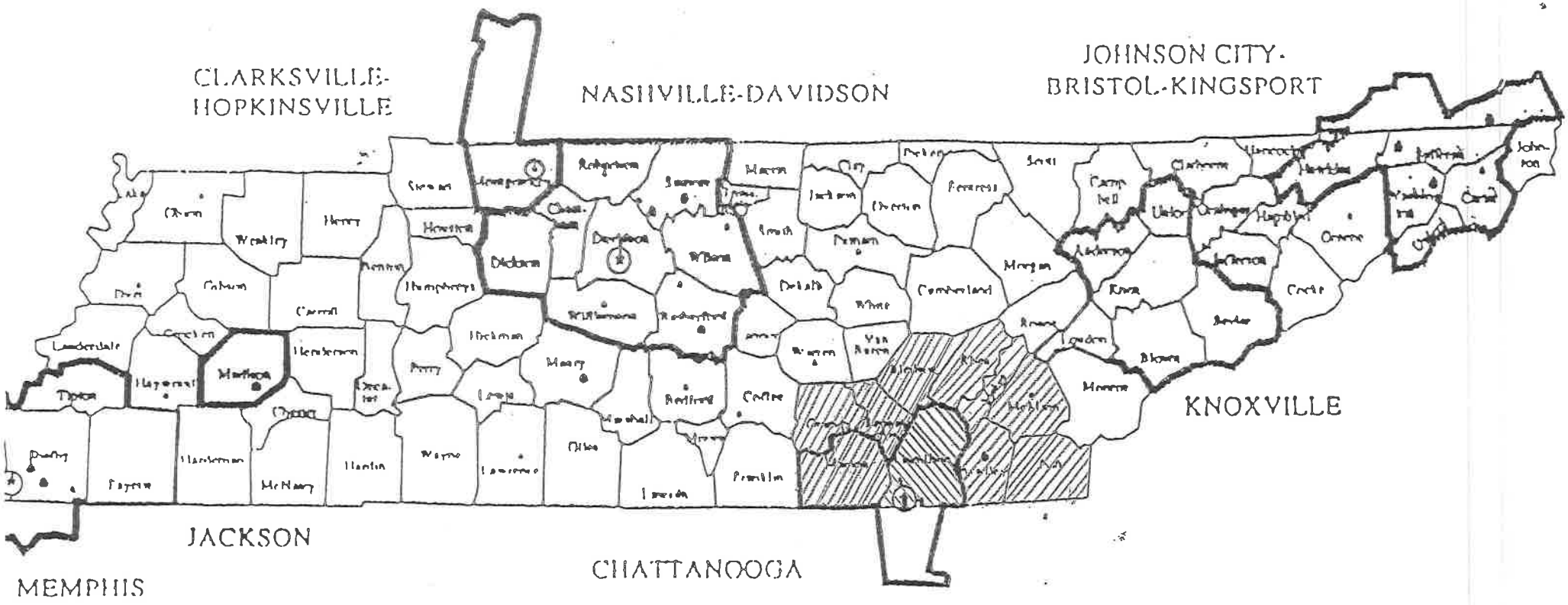


1. 38 ADDITION
2. ANCILLARY EAST
3. ANCILLARY WEST
4. ENGINEERING TRAILER
5. CARPENTER SHOP
6. CENTRAL ENERGY PLANT
7. CENTRAL INCINERATOT PLANT
8. CENTRAL WING
9. CONSTRUCTION SERVICES BUILDING
10. EAST WING
11. FILLAUER BUILDING
12. GENERATOR BUILDING
13. LAUNDRY
14. LIFE-FORCE HANGER
15. LP-1 STORAGE BUILDING
16. LP-2 GROUNDS SHOP
17. LP-3 MATERIAL MANAGEMENT
18. LP-4 FILTER STORAGE
19. MAGNETIC RESONANCE IMAGING
20. MASSOUD PEDIATRIC BUILDING
21. MILLER EYE CENTER
22. NORTH WING
23. PARKING GARAGE
24. PLAZZA AMBULATORY CARE
25. PROFESSIONAL OFFICE BUILDING
26. TAG-A-LONG TOTS
27. WEST WING
28. WHITEHALL BUILDING
29. MEDICADE QUALIFIERS
30. INHOUSE CONSTRUCTION SHOP
31. WHITEHALL PARKING GARAGE
32. VALET PARKING
33. MEDICAL MALL
34. UT. FAMILY PRACTICE
35. MEDICAL TOWERS



ERLANGER HOSPITAL - MRI ADDITION TO WOMEN'S CENTER
MEDICAL MALL - GROUND FLOOR - SCHEMATIC PLAN

DERTHICK HENLEY & WILKERSON ARCHITECTS 4 SEPTEMBER 2014


CLARKSVILLE-
HOPKINSVILLE
NASHVILLE-DAVIDSON
JOHNSON CITY-
BRISTOL-KINGSPORT
KNOXVILLE
JACKSON
CHATTANOOGA
MEMPHIS
Primary Service Area
Secondary Service Area

erlanger

September 5, 2014

Ms. Melanie M. Hill, Executive Director
Tennessee Health Services & Development Agency
500 Deadrick Street, Ste. 850
Nashville, TN 37243

RE: MRI (Tesla 3.0) Scanner
Erlanger Medical Center

Dear Ms. Hill:

This letter serves to confirm Erlanger's intent to fund the cost of the new MRI (Tesla 3.0) scanner of $ 4,597,711 with funds from operations; subject to CON approval as well as approval of the Chattanooga-Hamilton County Hospital Authority.

Please let me know if you have any questions or need further information. Thank you for your consideration.

Sincerely,

J. Britton Tabor, CPA
Executive Vice President
CFO & Treasurer

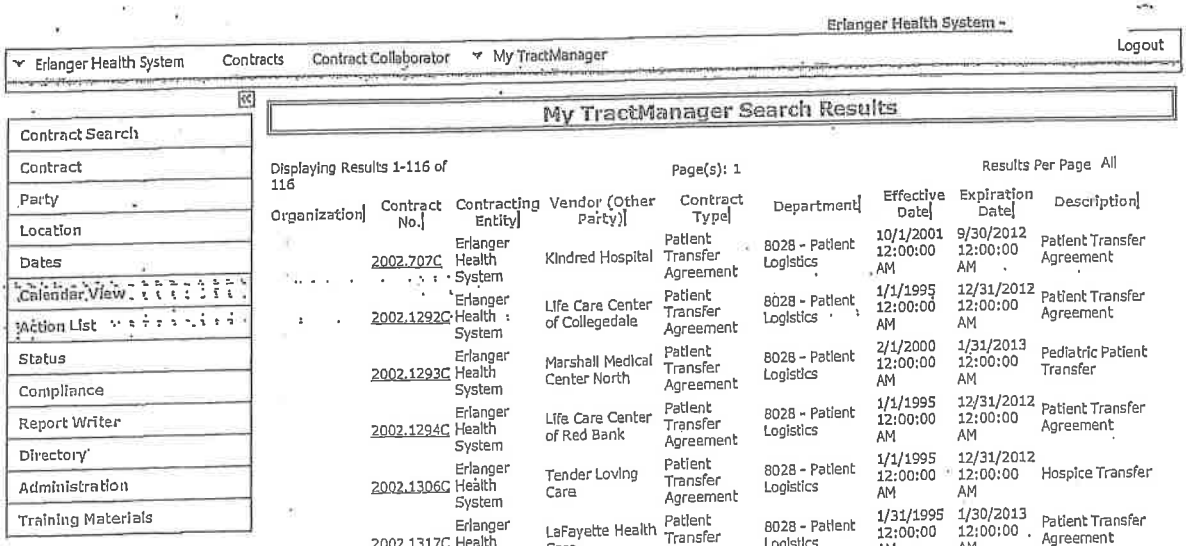
EHS -- Analysis Of Average Inpatient Charges
For CY 2013

	Erlanger Med Ctr	Memorial Hosp	Parkridge Med Ctr	Erlanger East	Memorial Hosp-Hixson	Parkridge East Hosp
Adverse Effects	23,632	24,363	25,768		20,302	26,192
Back & Spine	56,372	62,321	77,068		19,805	63,991
Burns	41,854		79,165			18,129
Cardiac Surgery	121,317	124,382	187,761			
Dermatology	12,638	18,047	22,945		15,063	22,421
Electrophysiology / Devices	68,224	64,498	137,067		33,055	106,849
Endocrinology	16,973	20,382	34,172		15,515	30,963
Gastroenterology	20,922	23,279	37,279	7,649	19,865	31,826
General Cardiology	20,092	23,017	33,878		20,564	32,532
General Surgery	56,962	44,511	72,165	44,632	33,317	44,307
Gynecology	30,925	34,881	41,628	22,990	19,142	27,419
Hematology	18,019	25,238	55,193		24,342	38,090
HIV Infection	43,118	36,835	38,690		17,866	42,950
Infectious Diseases	48,905	48,026	78,291		29,658	67,501
Invasive Cardiology	46,338	43,668	89,668		33,878	84,705
Neonatology	57,502			10,439		45,521
Nephrology	19,648	24,320	35,305	11,355	19,051	31,393
Neurology	27,860	25,879	36,859		22,363	33,884
Neurosurgery	69,488	35,049	49,150		29,527	39,255
Obstetrics	11,227	12,221	8,801	7,956	5,393	13,730
Oncology	27,498	35,313	59,406		23,053	53,594
Ophthalmology	19,265	17,105	40,009		12,855	30,541
Oral Surgery	15,522	16,295	20,298		14,870	23,542
Orthopedics	45,886	40,948	51,258	39,291	37,175	49,102
Other	69,279	49,940	104,685	19,106	52,845	57,632
Otolaryngology	27,603	22,553	22,753		13,316	34,818
Plastic Surgery	48,458	33,725	49,094		23,011	79,799
Psychiatry	16,521	16,554	41,849		19,930	29,693
Pulmonary Medicine	70,570	40,588	54,690		27,048	45,488
Rehabilitation			59,765			
Rheumatology	26,923	28,367	35,702		11,344	85,627
Signs & Symptoms	15,456	19,239	30,847		14,499	34,786
Substance Abuse	17,311	20,504	35,410		17,257	32,229
Thoracic Surgery	43,438	55,261	81,953		18,872	61,596
Transplant Surgery	133,754	297,366	#DIV/0!			
Urology	35,591	37,434	46,512	25,739	20,151	29,775
Vascular Diseases	16,605	20,754	28,747		13,739	26,520
Vascular Surgery	67,895	75,014	100,399		48,503	108,824
Total	37,396	40,269	61,289	9,085	25,131	29,292

Source: EHS Planning

9/9/2014 2:44 PM

TractManager



Erlanger Health System –

Erlanger Health System | Contracts | Contract Collaborator | My TractManager | Logout

- Contract Search
- Contract
- Party
- Location
- Dates
- Calendar View
- Action List
- Status
- Compliance
- Report Writer
- Directory
- Administration
- Training Materials

My TractManager Search Results

Displaying Results 1-116 of 116 — Page(s): 1 — Results Per Page All

Organization	Contract No.	Contracting Entity	Vendor (Other Party)	Contract Type	Department	Effective Date	Expiration Date	Description
	2002.707C	Erlanger Health System	Kindred Hospital	Patient Transfer Agreement	8028 - Patient Logistics	10/1/2001 12:00:00 AM	9/30/2012 12:00:00 AM	Patient Transfer Agreement
	2002.1292C	Erlanger Health System	Life Care Center of Collegedale	Patient Transfer Agreement	8028 - Patient Logistics	1/1/1995 12:00:00 AM	12/31/2012 12:00:00 AM	Patient Transfer Agreement
	2002.1293C	Erlanger Health System	Marshall Medical Center North	Patient Transfer Agreement	8028 - Patient Logistics	2/1/2000 12:00:00 AM	1/31/2013 12:00:00 AM	Pediatric Patient Transfer
	2002.1294C	Erlanger Health System	Life Care Center of Red Bank	Patient Transfer Agreement	8028 - Patient Logistics	1/1/1995 12:00:00 AM	12/31/2012 12:00:00 AM	Patient Transfer Agreement
	2002.1306C	Erlanger Health System	Tender Loving Care	Patient Transfer Agreement	8028 - Patient Logistics	1/1/1995 12:00:00 AM	12/31/2012 12:00:00 AM	Hospice Transfer
	2002.1317C	Erlanger Health System	LaFayette Health Care	Patient Transfer Agreement	8028 - Patient Logistics	1/31/1995 12:00:00 AM	1/30/2013 12:00:00 AM	Patient Transfer Agreement
	2002.1321C	Erlanger Health System	Jefferson Memorial Hospital	Patient Transfer Agreement	8028 - Patient Logistics	10/22/2004 12:00:00 AM	6/30/2013 12:00:00 AM	Patient Transfer Agreement
	2002.1336C	Erlanger Health System	Mountain Creek Manor	Patient Transfer Agreement	8028 - Patient Logistics	1/20/1995 12:00:00 AM	1/19/2013 12:00:00 AM	Patient Transfer Agreement
	2002.1337C	Erlanger Health System	Murphy Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	4/1/2000 12:00:00 AM	3/31/2013 12:00:00 AM	Pediatric Patient Transfer Agreement
	2002.1338C	Erlanger Health System	National Health Care of Chattanooga	Patient Transfer Agreement	8028 - Patient Logistics	7/20/2009 12:00:00 AM	7/19/2012 12:00:00 AM	Patient Transfer Agreement
	2002.1341C	Erlanger Health System	S.P. Acquisition Corporation d/b/a Grandview Medical Center f/k/a North Valley Medical Plaza	Patient Transfer Agreement	8028 - Patient Logistics	6/26/2009 12:00:00 AM	6/24/2013 12:00:00 AM	Patient Transfer
	2002.1342C	Erlanger Health System	Northside Hospital	Patient Transfer Agreement	8028 - Patient Logistics	4/10/1992 12:00:00 AM	4/9/2013 12:00:00 AM	Patient Transfer Agreement
	2002.1363C	Erlanger Health System	Renaissance Rehabilitation	Patient Transfer Agreement	8028 - Patient Logistics	4/26/1990 12:00:00 AM	4/25/2013 12:00:00 AM	Patient Transfer Agreement
	2002.1372C	Erlanger Health System	Rivermont Convalescent Center	Patient Transfer Agreement	8028 - Patient Logistics	1/25/1995 12:00:00 AM	1/24/2013 12:00:00 AM	Patient Transfer
	2002.1384C	Erlanger Health System	The Health Center at Standifer Place	Patient Transfer Agreement	8028 - Patient Logistics	6/18/2012 12:00:00 AM	6/17/2013 12:00:00 AM	Patient Transfer
	2002.1385C	Erlanger Health System	Shepherd Hills Health Care Center	Patient Transfer Agreement	8028 - Patient Logistics	1/25/1995 12:00:00 AM	1/24/2013 12:00:00 AM	Patient Transfer Agreement
	2002.1388C	Erlanger Health System	Methodist Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	2/6/2002 12:00:00 AM	6/30/2013 12:00:00 AM	Patient Transfer Agreement
	2002.1389C	Erlanger Health System	Brookewood Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	2/6/2002 12:00:00 AM	6/30/2013 12:00:00 AM	Patient Transfer Agreement
	2002.1390C	Erlanger Health System	Continuum Care Corporation d/b/a Spring City Health Care Center	Patient Transfer Agreement	8028 - Patient Logistics	2/1/1999 12:00:00 AM	1/31/2013 12:00:00 AM	Patient Transfer Agreement
	2002.1391C	Erlanger Health System	Newport Medical Center f/k/a Baptist Hospital Cocke County	Patient Transfer Agreement	8028 - Patient Logistics	7/14/2009 12:00:00 AM	7/13/2012 12:00:00 AM	Patient Transfer
	2002.1430C	Erlanger Health System	Bledsoe Community Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	7/29/2009 12:00:00 AM	7/28/2012 12:00:00 AM	Patient Transfer
	2002.1439C	Erlanger Health System	White County Community Hospital	Patient Transfer Agreement	8028 - Patient Logistics	6/29/2000 12:00:00 AM	6/28/2013 12:00:00 AM	Pediatric Patient Transfer Agreement
	2002.1441E	Erlanger Health	Consulate Health Care f/k/a	Patient Transfer	8028 - Patient Logistics	1/28/2009 12:00:00	1/27/2012 12:00:00	Patient Transfer Agreement

	System	Stratford House	Agreement		AM	AM	
2002.1446C	Erlanger Health System	The University of Tennessee Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	5/29/2002 12:00:00 AM	6/30/2013 12:00:00 AM	Patient Transfer Agreement
2002.1461C	Erlanger Health System	Erlanger Bledsoe	Patient Transfer Agreement	8028 - Patient Logistics	10/1/2001 12:00:00 AM	6/30/2013 12:00:00 AM	Patient Transfer Agreement
2002.1483C	Erlanger Health System	Cookeville Regional Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	2/10/2010 12:00:00 AM	2/9/2013 12:00:00 AM	Patient Transfer Agreement
2002.1498C	Erlanger Health System	Scott County Hospital	Patient Transfer Agreement	8028 - Patient Logistics	1/11/2001 12:00:00 AM	6/30/2013 12:00:00 AM	Patient Transfer Agreement
2002.1499C	Erlanger Health System	Wellmont Health Systems	Patient Transfer Agreement	8028 - Patient Logistics	6/30/2001 12:00:00 AM	6/30/2013 12:00:00 AM	Patient Transfer Agreement
2002.1502C	Erlanger Health System	Laughlin Memorial Hospital, Inc	Patient Transfer Agreement	8028 - Patient Logistics	11/23/2011 12:00:00 AM	11/22/2012 12:00:00 AM	Patient Transfer Agreement
2002.1539C	Erlanger Health System	Fort Sanders Park West Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	10/22/1999 12:00:00 AM	10/21/2012 12:00:00 AM	Patient Transfer Agreement
2002.1540C	Erlanger Health System	Ft Oglethorpe Nursing Home	Patient Transfer Agreement	8028 - Patient Logistics	1/12/2012 12:00:00 AM	1/11/2013 12:00:00 AM	Patient Transfer Agreement
2002.1550C	Erlanger Health System	Johnson City Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	5/29/2002 12:00:00 AM	6/30/2013 12:00:00 AM	Patient Transfer Agreement
2002.1576C	Erlanger Health System	Life Care Center of Chattanooga	Patient Transfer Agreement	8028 - Patient Logistics	1/25/1995 12:00:00 AM	1/24/2013 12:00:00 AM	Patient Transfer Agreement
2002.1594C	Erlanger Health System	St Barnabas Nursing Home	Patient Transfer Agreement	8028 - Patient Logistics	1/25/1995 12:00:00 AM	1/24/2013 12:00:00 AM	Patient Transfer Agreement
2002.1599C	Erlanger Health System	North Jackson Hospital	Patient Transfer Agreement	8028 - Patient Logistics	2/1/2000 12:00:00 AM	1/31/2013 12:00:00 AM	Pediatric Patient Transfer Agreement
2002.1605C	Erlanger Health System	National Healthcare of Rossville	Patient Transfer Agreement	8028 - Patient Logistics	5/17/2012 12:00:00 AM	5/16/2013 12:00:00 AM	Patient Transfer Agreement
2002.1606C	Erlanger Health System	National Health Care of Fort Oglethorpe	Patient Transfer Agreement	8028 - Patient Logistics	5/22/2012 12:00:00 AM	5/21/2013 12:00:00 AM	Patient Transfer Agreement
2002.1607C	Erlanger Health System	National Healthcare of Dunlap	Patient Transfer Agreement	8028 - Patient Logistics	6/20/2012 12:00:00 AM	6/19/2013 12:00:00 AM	Patient Transfer Agreement
2002.1608C	Erlanger Health System	National Healthcare of Athens	Patient Transfer Agreement	8028 - Patient Logistics	5/15/2012 12:00:00 AM	5/14/2013 12:00:00 AM	Patient Transfer Agreement
2002.1623C	Erlanger Health System	Shriners Hospitals for Children	Patient Transfer Agreement	8028 - Patient Logistics	7/1/2000 12:00:00 AM	6/30/2013 12:00:00 AM	Pediatric Patient Transfer Agreement
2002.1634C	Erlanger Health System	Rhea Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	2/6/2002 12:00:00 AM	6/30/2013 12:00:00 AM	Patient Transfer Agreement
2002.1670C	Erlanger Health System	Alexian Village of Chattanooga	Patient Transfer Agreement	8028 - Patient Logistics	1/1/1995 12:00:00 AM	12/31/2012 12:00:00 AM	Patient Transfer Agreement
2002.1685C	Erlanger Health System	Blount Memorial Hospital	Patient Transfer Agreement	8028 - Patient Logistics	2/7/2001 12:00:00 AM	2/6/2013 12:00:00 AM	Pediatric Patient Transfer Agreement
2002.1686E	Erlanger Health System	Bradley Healthcare & Rehabilitation f/k/a Bradley County Nursing Home	Patient Transfer Agreement	8028 - Patient Logistics	3/23/2009 12:00:00 AM	3/22/2012 12:00:00 AM	Patient Transfer Agreement
2002.1709C	Erlanger Health System	Chattanooga Surgery Center	Patient Transfer Agreement	8028 - Patient Logistics	11/17/2010 12:00:00 AM	11/16/2012 12:00:00 AM	Patient Transfer Agreement
2002.1714C	Erlanger Health System	Columbia Indian Path Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	1/13/1997 12:00:00 AM	1/12/2013 12:00:00 AM	Patient Transfer Agreement
2002.1715C	Erlanger Health System	Columbia East Ridge Hospital	Patient Transfer Agreement	8028 - Patient Logistics	3/31/1998 12:00:00 AM	3/30/2013 12:00:00 AM	Pediatric Patient Transfer Agreement
2002.1716C	Erlanger Health System	East Ridge Hospital	Patient Transfer Agreement	8028 - Patient Logistics	10/22/1996 12:00:00 AM	10/21/2012 12:00:00 AM	Patient Transfer Agreement
2002.1717C	Erlanger Health System	NovaMed Eye and Laser Surgery, Center of	Patient Transfer Agreement	8028 - Patient Logistics	6/27/2002 12:00:00 AM	6/30/2013 12:00:00 AM	Patient Transfer Agreement
2002.1750C	Erlanger Health System	Jamestown Regional Medical Center, f/k/a Fentress County Hospital	Patient Transfer Agreement	8028 - Patient Logistics	5/14/2012 12:00:00 AM	5/13/2013 12:00:00 AM	Patient Transfer Agreement
2002.1751C	Erlanger Health	Gadsden Regional Medical	Patient Transfer	8028 - Patient Logistics	8/11/2009 12:00:00	8/10/2012 12:00:00	Patient Transfer Agreement

	System	Center	Agreement		AM	AM	
2002.1753C	Erlanger Health System	Emory Cartersville Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	5/21/2012 12:00:00 AM	5/20/2013 12:00:00 AM	Patient Transfer Agreement
2002.1766C	Erlanger Health System	Healthsouth Chattanooga Surgery Center	Patient Transfer Agreement	8028 - Patient Logistics	4/13/1999 12:00:00 AM	6/30/2013 12:00:00 AM	Patient Transfer Agreement
2002.1768C	Erlanger Health System	Harton Regional Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	12/8/2011 12:00:00 AM	12/7/2012 12:00:00 AM	Patient Transfer Agreement
2002.2377C	Erlanger Health System	St Mary's Health System, Inc	Patient Transfer Agreement	8028 - Patient Logistics	4/1/2003 12:00:00 AM	3/31/2013 12:00:00 AM	Patient Transfer Agreement
2002.2531E	Erlanger Health System	Memorial North Park Hospital	Patient Transfer Agreement	8028 - Patient Logistics	3/10/2009 12:00:00 AM	3/9/2012 12:00:00 AM	Patient Transfer Agreement
2002.2690E	Erlanger Health System	United Regional Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	9/28/2008 12:00:00 AM	9/28/2011 12:00:00 AM	Patient Transfer Agreement
2002.2692C	Erlanger Health System	Southern Tennessee Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	9/29/2010 12:00:00 AM	9/28/2012 12:00:00 AM	Patient Transfer Agreement
2002.2693C	Erlanger Health System	Riverview Regional Medical Center North, f/k/a Smith County Hospital	Patient Transfer Agreement	8028 - Patient Logistics	12/5/2011 12:00:00 AM	12/4/2012 12:00:00 AM	Patient Transfer Agreement
2002.2694E	Erlanger Health System	Siskin Hospital for Physical Rehabilitation	Patient Transfer Agreement	8028 - Patient Logistics	10/18/2008 12:00:00 AM	10/16/2011 12:00:00 AM	Pediatric Patient Transfer Agreement
2002.2695E	Erlanger Health System	Roane Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	9/28/2008 12:00:00 AM	9/27/2011 12:00:00 AM	Patient Transfer Agreement
2002.2696E	Erlanger Health System	Rhea County Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	9/28/2008 12:00:00 AM	9/27/2011 12:00:00 AM	Patient Transfer Agreement
2002.2697C	Erlanger Health System	Redmond Regional Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	1/17/2012 12:00:00 AM	1/16/2013 12:00:00 AM	Patient Transfer Agreement
2002.2699C	Erlanger Health System	Murray Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	12/5/2011 12:00:00 AM	12/4/2012 12:00:00 AM	Patient Transfer Agreement
2002.2700C	Erlanger Health System	Medical Center of Manchester	Patient Transfer Agreement	8028 - Patient Logistics	4/19/2012 12:00:00 AM	4/18/2013 12:00:00 AM	Patient Transfer Agreement
2002.2701C	Erlanger Health System	Livingston Regional Hospital	Patient Transfer Agreement	8028 - Patient Logistics	12/5/2011 12:00:00 AM	12/4/2012 12:00:00 AM	Patient Transfer Agreement
2002.2702C	Erlanger Health System	Lincoln County Health System	Patient Transfer Agreement	8028 - Patient Logistics	11/30/2011 12:00:00 AM	11/29/2012 12:00:00 AM	Patient Transfer Agreement
2002.2703C	Erlanger Health System	Hamilton Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	11/22/2011 12:00:00 AM	11/21/2012 12:00:00 AM	Patient Transfer
2002.2704C	Erlanger Health System	Fannin Regional Hospital	Patient Transfer Agreement	8028 - Patient Logistics	6/18/2012 12:00:00 AM	6/17/2013 12:00:00 AM	Patient Transfer
2002.2705E	Erlanger Health System	Southern Tennessee Medical Center d/b/a Emerald Hodgson Hospital	Patient Transfer Agreement	8028 - Patient Logistics	10/17/2008 12:00:00 AM	10/16/2011 12:00:00 AM	Patient Transfer Agreement
2002.2706C	Erlanger Health System	Cumberland Medical Center, Inc	Patient Transfer Agreement	8028 - Patient Logistics	12/2/2011 12:00:00 AM	12/1/2012 12:00:00 AM	Patient Transfer
2002.2707C	Erlanger Health System	Copper Basin Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	12/1/2011 12:00:00 AM	11/30/2012 12:00:00 AM	Patient Transfer Agreement
2002.2717E	Erlanger Health System	Cherokee Medical Center f/k/a Baptist Cherokee Hospital	Patient Transfer Agreement	8028 - Patient Logistics	9/28/2008 12:00:00 AM	9/27/2011 12:00:00 AM	Patient Transfer Agreement
2002.2739E	Erlanger Health System	Athens Regional Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	9/29/2008 12:00:00 AM	9/27/2011 12:00:00 AM	Patient Transfer Agreement
	Erlanger	Chatuge	Patient		12/1/2011	11/30/2012	

2002.2746C	Health System	Regional Hospital	Transfer Agreement	8028 - Patient Logistics	12:00:00 AM	12:00:00 AM	Patient Transfer Agreement
2002.2777C	Erlanger Health System	Sparta Hospital Corporation d/b/a White County Hospital, LLC	Patient Transfer Agreement	8028 - Patient Logistics	4/25/2012 12:00:00 AM	4/24/2013 12:00:00 AM	Patient Transfer Agreement
2002.2788C	Erlanger Health System	Chattanooga Imaging	Patient Transfer Agreement	8028 - Patient Logistics	12/30/2010 12:00:00 AM	12/29/2012 12:00:00 AM	Patient Transfer Agreement
2002.2830C	Erlanger Health System	Gordon Hospital	Patient Transfer Agreement	8028 - Patient Logistics	7/1/2012 12:00:00 AM	6/30/2013 12:00:00 AM	Patient Transfer Agreement
2002.2854E	Erlanger Health System	Chattanooga Rehabilitation Hospital	Patient Transfer Agreement	8028 - Patient Logistics	2/3/2009 12:00:00 AM	2/2/2012 12:00:00 AM	Patient Transfer Agreement
2002.2891E	Erlanger Health System	DeKalb Regional Medical Center, f/k/a Baptist DeKalb Hospital	Patient Transfer Agreement	8028 - Patient Logistics	9/28/2008 12:00:00 AM	9/27/2011 12:00:00 AM	Patient Transfer Agreement
2002.3545C	Erlanger Health System	National Healthcare of Cleveland, Inc. d/b/a Skyridge Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	1/10/2007 12:00:00 AM	10/6/2012 12:00:00 AM	Patient Transfer Agreement
2002.3609E	Erlanger Health System	Atrium Surgery Center	Patient Transfer Agreement	8028 - Patient Logistics	7/28/2009 12:00:00 AM	6/27/2012 12:00:00 AM	Patient Transfer Agreement
2002.3688C	Erlanger Health System	Burks GenCore Co., Inc. d/b/a The Genesis Group	IT: Non Clinical Software	7149 - LifeForce Communications	12/21/2007 12:00:00 AM	12/20/2012 12:00:00 AM	GenWatch 3 FEU Hospital Disaster Recovery Monitor System Software
2002.3815C	Erlanger Health System	Memorial Mission Surgery Center	Patient Transfer Agreement	8028 - Patient Logistics	12/14/2011 12:00:00 AM	12/13/2012 12:00:00 AM	Patient Transfer Agreement
2002.4049C	Erlanger Health System	Vanderbilt University Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	7/1/2008 12:00:00 AM	6/30/2013 12:00:00 AM	Burn Patient Transfer
2002.4187E	Erlanger Health System	Doctors Hospital of Augusta, LLC d/b/a Doctors Hospital	Patient Transfer Agreement	8028 - Patient Logistics	2/23/2009 12:00:00 AM	2/22/2011 12:00:00 AM	Patient Transfer
2002.4215E	Erlanger Health System	Memorial Health Care System, Inc., a Kentucky non-profit corporation, d/b/a Memorial Hospital (Memorial On Call)	Patient Transfer Agreement	8028 - Patient Logistics	3/10/2009 12:00:00 AM	3/9/2012 12:00:00 AM	Patient Transfer: Bledsoe
2002.4635E	Erlanger Health System	Hutcheson Medical Center, Inc. d/b/a Hutcheson Medical Center	Patient Transfer Agreement	8028 - Patient Logistics	5/13/2010 12:00:00 AM	5/12/2011 12:00:00 AM	Patient Transfer: Percutaneous Cardiac Intervention
2002.4833C	Erlanger Health System	Eye Surgery Center of Chattanooga	Patient Transfer Agreement	8028 - Patient Logistics	9/15/2010 12:00:00 AM	9/14/2012 12:00:00 AM	Patient Transfer
2002.4857C	Erlanger Health System	Life Care Center of East Ridge	Patient Transfer Agreement	8028 - Patient Logistics	11/10/2010 12:00:00 AM	11/9/2012 12:00:00 AM	Patient Transfer
2002.4874C	Erlanger Health System	Life Care Center of Hixson	Patient Transfer Agreement	8028 - Patient Logistics	1/1/2011 12:00:00 AM	12/31/2012 12:00:00 AM	Patient Transfer
2002.5425C	Erlanger Health System	Renaissance Surgery Center	Patient Transfer Agreement	8028 - Patient Logistics	2/16/2012 12:00:00 AM	2/15/2013 12:00:00 AM	Patient Transfer Agreement

Board for Licensing Health Care Facilities

State of Tennessee

0000000140

No. of Beds 0788

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY *to conduct and maintain a*

Hospital ERLANGER MEDICAL CENTER

Located at 975 EAST THIRD STREET, CHATTANOOGA

County of HAMILTON *, Tennessee.*

This license shall expire JUNE 04 , 2015 , *and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 4TH *day of* JUNE , 2014 .

In the Distinct Category(ies) of:
GENERAL HOSPITAL
PEDIATRIC CPRC HOSPITAL
TRAUMA CENTER LEVEL 1

By Vincent J. Davis, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By John J. Dreyzehner, MD
COMMISSIONER

DCF013

The Joint Commission

July 8, 2014

Re: # 7809
CCN: #440104
Program: Hospital
Accreditation Expiration Date: April 05, 2017

Kevin M. Spiegel
President and CEO
Erlanger Health System
975 East Third Street
Chattanooga, Tennessee 37403

Dear Mr. Spiegel:

This letter confirms that your March 31, 2014 - April 04, 2014 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on June 20, 2014 and June 27, 2014 and the successful on-site Medicare Deficiency Follow-up event conducted on May 19, 2014, the areas of deficiency listed below have been removed. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of April 05, 2014. We congratulate you on your effective resolution of these deficiencies.

§482.12 Governing Body
§482.41 Physical Environment
§482.42 Infection Control

The Joint Commission is also recommending your organization for continued Medicare certification effective April 05, 2014. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following locations:

Academc Internal Medicine and Endocrinology
979 E. Third Street, Suite B-601, Chattanooga, TN, 37403

Academic Gastroenterology
979 East Third Street, Suite C-825, Chattanooga, TN, 37403

Academic Urologist at Erlanger
979 East Third Street, Suite C - 535, Chattanooga, TN, 37403

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

The Joint Commission

Alton Park (Southside) Community Health Center
100 East 37th Street, Chattanooga, TN, 37410

Dodson Avenue Community Health Center
1200 Dodson Avenue, Chattanooga, TN, 37406

Erlanger Academic Urologists
1755 Gunbarrel Road, Suite 209, Chattanooga, TN, 37421

Erlanger at Volkswagon Drive Wellness Center
7380 Volkswagon Drive, Suite 110, Chattanooga, TN, 37416

Erlanger East Family Practice
1755 Gunbarrel Road, Suite 201, Chattanooga, TN, 37421

Erlanger East Imaging
1751 Gunbarrel Road, Chattanooga, TN, 37421

Erlanger Health System - East Campus
1751 Gunbarrel Road, Chattanooga, TN, 37421

Erlanger Health System - Main Site
975 East Third Street, Chattanooga, TN, 37403

Erlanger Health System - North Campus
632 Morrison Springs Road, Chattanooga, TN, 37415

Erlanger Hypertension Management Center
979 East Third Street, Suite B601, Chattanooga, TN, 37403

Erlanger Metabolic and Bariatric Surgery Center
979 E. Third Street Suite C-620, Chattanooga, TN, 37403

Erlanger Neurology/Southeast Regional Stroke Center
979 East Third Street, Suite C830, Chattanooga, TN, 37403

Erlanger North Family Practice, Neurobehavioral & Memory Svs
632 Morrison Springs Road, Suite 202, Chattanooga, TN, 37415

Erlanger North Sleep Medicine and Neurology
632 Morrison Springs Road, Suite 300, Chattanooga, TN, 37415

Erlanger South Family Practice
60 Erlanger Drive, Suite A, Ringgold, GA, 30736

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

The Joint Commission

Erlanger Specialty Care for OB and Peds
1504 North Thornton Avenue, Suite 104, Dalton, GA, 30720

Hypertension Management - Chattanooga Lifestyle Center
325 Market Street, Suite 200, Chattanooga, TN, 37401

Life Style Center - Cardiac Rehab
325 Market Street, Chattanooga, TN, 37401

Ortho South
979 East Third Street suite C 430, Chattanooga, TN, 37403

Southern Orthopaedic Trauma Surgeons
979 East Third Street Suite C-225, Chattanooga, TN, 37403

TCT Cardiology/GI/Genetics
910 Blackford Street - 3rd Fl Massoud, Chattanooga, TN, 37403

TCT Children's Subspecialty Center
2700 West Side Drive, Cleveland, TN, 37312

TCT Endocrine
910 Blackford, 1st fl Massoud, Chattanooga, TN, 37403

TCT Hematology/Oncology
910 Blackford Street - 5th fl Massoud Bl, Chattanooga, TN, 37403

TCT Nephrology
910 Blackford St, Ground Level, TCTCH, Chattanooga, TN, 37403

University Health Obstetrics & Gynecology
979 East Third Street, Suite C-725, Chattanooga, TN, 37403

University Medical Assoc
960 East Third Street, Whitehall Building, Suite 208, Chattanooga, TN, 37403

University Orthopedics
979 East Third Street, Suite C-220, Chattanooga, TN, 37403

University Pediatrics
910 Blackford Street - Gr floor Massoud, Chattanooga, TN, 37403

University Pulmonary and Critical Care
979 East Third Street, Suite C 735, Chattanooga, TN, 37403

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

The Joint Commission

University Rheumatology Associates
979 East Third Street, Suite B-805, Chattanooga, TN, 37403

UT Dermatology
979 East Third Street, - Suite 425 A - Med Mall, Chattanooga, TN, 37403

UT Erlanger Cardiology
975 East Third Street, Suite C-520, Chattanooga, TN, 37403

UT Erlanger Cardiology East
1614 Gunbarrel Road, Ste 101, Chattanooga, TN, 37421

Ut Erlanger Health & Wellness@Signal Mtn
2600 Taft Highway, Signal Mountain, TN, 37377

UT Erlanger Lookout Mtn Primary Care
100 McFarland Road, Lookout Mountain, GA, 30750

UT Erlanger Primary and Athletic Health
1200 Pineville Road, Chattanooga, TN, 37405

UT Family Practice
1100 East Third Street, Chattanooga, TN, 37403

Workforce at UT Family Practice
1100 East 3rd Street, Chattanooga, TN, 37403

We direct your attention to some important Joint Commission policies. First, your Medicare report is publicly accessible as required by the Joint Commission's agreement with the Centers for Medicare and Medicaid Services. Second, Joint Commission policy requires that you inform us of any changes in the name or ownership of your organization, or health care services you provide.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 4 /Survey and Certification Staff

www.jointcommission.org

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG. 1
KNOXVILLE, TENNESSEE 37919

September 03, 2013

Mr. Kevin Spiegel, Administrator
Erlanger Medical Center
975 E 3rd St
Chattanooga TN 37403

RE: 44-0104

Dear Mr. Spiegel:

The East Tennessee Regional Office conducted a complaint investigation at your facility on August 27-29, 2013. As a result of the investigation, no deficient practice was found.

If our office may be of assistance to you, please feel free to call (865) 588-5656.

Sincerely,

Karen B Kirby RN

Karen B. Kirby, RN
Regional Administrator
East TN Health Care Facilities

KK: kg

TN00031884 & TN00032253

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

A – 31

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE COMPLETED
	440104	A. BUILDING _____ B. WING _____	C 08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ERLANGER MEDICAL CENTER	975 E 3RD ST CHATTANOOGA, TN 37403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS During investigation of complaints #31884 and #32253 at Erlanger Medical Center on August 29, 2013, no deficiencies were cited under 42CFR Part 482, Requirements for Hospitals.	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531140	A. BUILDING: _____ B. WING _____	C 08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ERLANGER MEDICAL CENTER	975 E 3RD ST CHATTANOOGA, TN 37403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 001	1200-8-1 Initial This Rule is not met as evidenced by: During investigation of complaints #31884 and #32253 at Erlanger Medical Center on August 29, 2013, no deficiencies were cited under 1200-8-1, Standards for Hospitals.	H 001		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

A – 33

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Food and Drug Administration
10903 New Hampshire Avenue
Document Control Room – WO66-G609
Silver Spring, MD 20993-0002

Ms. Kim Rendon
Manager, Regulatory/Clinical Affaris
Siemens Medical Solutions USA, Inc.
51 Valley Stream Pkwy, Mail Code G01
MALVERN PA 19355

OCT 1 2010

Re: K101347
Trade/Device Name: Magnetom Aera and Magnetom Skyra
Regulation Number: 21 CFR 892.1000
Regulation Name: Magnetic resonance diagnostic device
Regulatory Class: II
Product Code: LNH and LNI
Dated: August 13, 2010
Received: August 16, 2010

Dear Ms. Rendon:

We have reviewed your Section 510(k) premarket notification of intent to market the device referenced above and have determined the device is substantially equivalent (for the indications for use stated in the enclosure) to legally marketed predicate devices marketed in interstate commerce prior to May 28, 1976, the enactment date of the Medical Device Amendments, or to devices that have been reclassified in accordance with the provisions of the Federal Food, Drug, and Cosmetic Act (Act) that do not require approval of a premarket approval application (PMA). You may, therefore, market the device, subject to the general controls provisions of the Act. The general controls provisions of the Act include requirements for annual registration, listing of devices, good manufacturing practice, labeling, and prohibitions against misbranding and adulteration.

If your device is classified (see above) into class II (Special Controls), it may be subject to such additional controls. Existing major regulations affecting your device can be found in Title 21, Code of Federal Regulations (CFR), Parts 800 to 895. In addition, FDA may publish further announcements concerning your device in the Federal Register.

Please be advised that FDA's issuance of a substantial equivalence determination does not mean that FDA has made a determination that your device complies with other requirements of the Act or any Federal statutes and regulations administered by other Federal agencies. You must comply with all the Act's requirements, including, but not limited to: registration and listing (21 CFR Part 807); labeling (21 CFR Parts 801 and 809); medical device reporting (reporting of

medical device-related adverse events) (21 CFR 803); and good manufacturing practice requirements as set forth in the quality systems (QS) regulation (21 CFR Part 820). This letter will allow you to begin marketing your device as described in your Section 510(k) premarket notification. The FDA finding of substantial equivalence of your device to a legally marketed predicate device results in a classification for your device and thus, permits your device to proceed to the market.

If you desire specific advice for your device on our labeling regulation (21 CFR Parts 801 and 809), please contact the Office of *In Vitro* Diagnostic Device Evaluation and Safety at (301) 796-5450. Also, please note the regulation entitled, "Misbranding by reference to premarket notification" (21 CFR Part 807.97). For questions regarding the reporting of adverse events under the MDR regulation (21 CFR Part 803), please go to http://www.fda.gov/MedicalDevices/Safety/ReportaProblem/default.htm for the CDRH's Office of Surveillance and Biometrics/Division of Postmarket Surveillance.

You may obtain other general information on your responsibilities under the Act from the Division of Small Manufacturers, International and Consumer Assistance at its toll-free number (800) 638-2041 or (301) 796-7100 or at its Internet address http://www.fda.gov/cdrh/industry/support/index.html.

Sincerely yours,

David G. Brown, Ph.D.
Acting Director
Division of Radiological Devices
Office of *In Vitro* Diagnostic Device
Evaluation and Safety
Center for Devices and Radiological Health

Enclosure

K101347

Section 4 Indications for Use Statement

510(k) Number (if known) _____

Device Names: MAGNETOM Aera and MAGNETOM Skyra.

Indications for Use:

The MAGNETOM systems described above are indicated for use as a magnetic resonance diagnostic device (MRDD) that produces transverse, sagittal, coronal and oblique cross sectional images, spectroscopic images and/or spectra, and that displays the internal structure and/or function of the head, body, or extremities.

Other physical parameters derived from the images and/or spectra may also be produced. Depending on the region of interest, contrast agents may be used. These images and/or spectra and the physical parameters derived from the images and/or spectra when interpreted by a trained physician yield information that may assist in diagnosis.

The MAGNETOM systems described above may also be used for imaging during interventional procedures when performed with MR compatible devices such as inroom display and MR-safe biopsy needles.

(please do not write below this line- continue on another page if needed)

Concurrence of CDRH, Office of Device Evaluation

Prescription Use X OR Over-The-Counter Use___

(Division Sign-Off)
Division of Radiological Devices
Office of In Vitro Diagnostic Device Evaluation and Safety

510K K101347

Blaise W. Baxter, MD
Curriculum Vitae

Tennessee Interventional Associates
975 East Third Street
Box 376
Chattanooga, TN 37403
423-778-7234
Baxter.blaise@gmail.com

Birthdate: January 16, 1963
Birthplace: Bracebridge, Ontario

Education:

Fellowship

University of Western Ontario
Dalhousie University
Halifax, Nova Scotia
Neuroradiology
1996 - 1998

Residency

Dalhousie University
Halifax, Nova Scotia
Diagnostic Imaging Residency
1992 - 1996

Internship

York-Finch General Hospital
Downsview, Ontario
Rotating Internship
1988 – 1989

Graduate/Medical School

Dalhousie University
Halifax, Nova Scotia
Doctor of Medicine
1984 - 1988

Undergraduate

University of King's College
Halifax, Nova Scotia
Bachelor of Science (Major in Biology)
1980 - 1984

Board Certification:

American Board of Radiology
Diagnostic Radiology
1996

Fellow of Royal College of Physicians and Surgeons
Diagnostic Radiology

1996

Medical Licensure: Tennessee License #31416

Society Memberships:

Society of Neuro Interventional Surgery

American Association of Neurological Surgeons / CNS Cerebrovascular Section

Chattanooga Hamilton County Medical Society

American College of Radiology

Radiology Society of North America

Tennessee Radiological Society

College of Physicians and Surgeons of Canada
American Society of Neuroradiology

University Appointments:

Neuro Interventional Surgery Fellowship
University of Tennessee College of Medicine
Program Director

Clinical Assistant Professor
University of Tennessee College of Medicine, Radiology and Surgery
Chief, Interventional Radiology
Erlanger Health System

Lecturer – Dalhousie University, Halifax, Nova Scotia.

Hospital Appointments:

Erlanger Medical Center
Chattanooga, Tennessee
Section Chief, Interventional Radiology
July 2007 – Present

Parkridge and East Ridge Medical Centers
Chattanooga, Tennessee
Chief of Radiology
February 2006 - 2008

Professional Experience:

Current Position	Tennessee Interventional Associates Interventional Radiologist Chattanooga, TN
1999—2011	Associates in Diagnostic Radiology, PC Diagnostic and Interventional Radiologist Chattanooga, Tennessee
1998 – 1999	QEII Health Sciences Centre Halifax Infirmary Halifax, Nova Scotia

1996 – 1998	Neuroradiology Fellowship University of Western Ontario Dalhousie University Halifax, Nova Scotia
1992 – 1996	Diagnostic Imaging Residency Dalhousie University Halifax, Nova Scotia
1991 – 1992	Flight Surgeon, Medical Officer CFB Greenwood, Nova Scotia
1989 – 1991	Flight Surgeon, Medical Officer CFB Summerside, PEI
1985 – 1986	Terry Fox Research Clerkship awarded by the National Institute of Canada, Dalhousie University Halifax, Nova Scotia

Awards and Honors:

Dr. Richard B. Goldbloom Award in Paediatrics, 1988

Terry Fox Research Scholarship - National Cancer Institute of Canada, 1985 – 1986

Entrance Scholarship – Dalhousie Medical School, Halifax, Nova Scotia, 1984

Entrance Scholarship - University of King's College, Halifax, Nova Scotia, Coleman-Pelham-Roach Scholarship, 1981

Lieutenant Governor's Medal, 1980

Professional Activities:

Leadership and Clinical Trial Committees

Steering Committee Member: Solitaire With the Intention For Thrombectomy (SWIFT) Trial. Study sponsored by ev3 Inc. 2007-present

Steering Committee Member: DWI or CTP Assessment with Clinical Mismatch in the Triage of Wake Up and Late Presenting Strokes Undergoing Neurointervention (DAWN) Trial. Study sponsored by Stryker. 2013 – present.

Steering Committee Member: PerfusiOn imaging Selection of Ischemic Stroke Patients for EndoVascular ThErapy (POSITIVE) Trial. Study sponsored by MUSC. 2013 – present.

Steering Committee Member: Trevo Registry. Study sponsored by Stryker. 2013 – present.

Medical Advisory Committee: Wingspan StEnt System Post MArket SurVEillance Study (WEAVE) Trial. Study sponsored by Stryker. 2013 – present.

Program Committee Member: Society of NeuroInterventional Surgery (SNIS). 2010 – present.

Editorial Services To Scholarly Publications

Reviewer, American Journal of Neuroradiology (1997 – 1998).

Reviewer, *Journal of NeuroInterventional Surgery* 2011 – present

Consulting Activities

Stryker/Concentric Medical, Freemont, CA. Consultant. 2006 – present.

Covidien/ev3 Inc., Irvine, CA. Consultant. 2009 – present.

Penumbra Inc., Alameda, CA. Consultant. 2009 – present.

Rapid Medical, Israel

Reverse Medical Corporation, Irvine, CA. 2009 – present.

Codman & Shurtleff, Inc., Raynham, MA. 2009 – present

Silk Road Medical, Inc., Sunnyvale, CA, 2012 – present.

Publications:

A Utility-Weighted Modified Rankin Scale: Derivation and Application to Completed Stroke Trials (P5.008). Chaisinanunkul N, Saver J, Jovin T, Berry S, Lewis R, Lees K, Furlan A, Baxter B, Lutsep H, Ribo M, Jansen O, Gupta R, Pereira-Mendes V and Nogueira R. *Neurology*. 2014 April 8.

ADAPT FAST Study: A Direct Aspiration First Pass Technique for Acute Stroke Thrombectomy. Turk AS, Frei D, Fiorella D, Mocco J, Baxter B, Siddiqui A, Spiotta A, Mokin M, Dewan M, Quarfordt S, Battenhouse H, Turner R, Chaudry I. *Journal of Neurointerventional Surgery*. Published Online First, 25 February 2014.

Initial Clinical Experience with the ADAPT Technique: A Direct Aspiration First Pass Technique for Stroke Thrombectomy. Turk AS, Spiotta A, Frei D, Mocco J, Baxter B, Fiorella D, Siddiqui A, Mokin M, Dewan M, Woo H, Turner R, Hawk H, Miranpuri A, Chaudry I. *Journal of Neurointerventional Surgery*. 2013 April.

A Trial of Imaging Selection and Endovascular Treatment for Ischemic Stroke.
Kidwell CS, Jahan R, Gornbein J, Alger JR, Nenov V, Ajani Z, Feng L, Meyer BC, Olson S, Schwamm LH, Yoo AJ, Marshall RS, Meyers PM, Yavagal DR, Wintermark M, Guzy J, Starkman S, Saver JL; MR RESCUE Investigators. *New England Journal of Medicine*. 2013 March.

Saver JL, Jahan R, Levy EI, Jovin TG, Baxter B, Nogueira R, Clark W, Budzik R, Zaidat OO; the SWIFT Trialists. SOLITAIRE™ with the intention for thrombectomy (SWIFT) trial: design of a randomized, controlled, multicenter study comparing the SOLITAIRE™ Flow Restoration device and the MERCI Retriever in acute ischaemic stroke. *Int J Stroke*. 2012 Nov 6.

Solitaire Flow Restoration Device Versus the Merci Retriever in Patients with Acute Ischaemic Stroke (SWIFT): a Randomised, Parallel-Group, Non-Inferiority Trial.
Saver JL, Jahan R, Levy EI, Jovin TG, Baxter B, Nogueira RG, Clark W, Budzik R, Zaidat OO; SWIFT Trialists. *Lancet*. 2012 October.

Putting the 'Eye' In IV Access – Unconventional Approaches in Head and Neck Intervention. Baxter B, Mayich M, Hungerford, J. *Journal of Neurointerventional Surgery*. Vol 4 Suppl 1:A68. Chattanooga, TN, Newfoundland, Canada, July 2012.

Imaging-Based Endovascular Therapy for Acute Ischemic Stroke due to Proximal Intracranial Anterior Circulation Occlusion Treated Beyond 8 Hours From Time Last Seen Well: Retrospective Multicenter Analysis of 237 Consecutive Patients. Tudor G Jovin, David S Liebeskind, Rishi Gupta, Marilyn Rymer, Ansaar Rai, Osama O Zaidat, Alex Abou-Chebl, Blaise Baxter, Elad I Levy, Andrew Barreto, Raul G Nogueira, *Stroke; a Journal of Cerebral Circulation*, 42(8):2206-11, August 2011.

For the Merci Registry Investigators. Endovascular Mechanical Thrombectomy for the Treatment of Acute Ischemic Stroke Due to Arterial Dissection. Jeremy D. Fields, MD; Helmi L. Lutsep, MD; Marilyn R. Rymer,

MD; Ronald F. Budzik, MD; Thomas G. Devlin, MD, PhD; Blaise W. Baxter, MD; Reza Malek, MD, MsC; Arash M. Padidar, MD; Stanley L. Barnwell, MD, PhD; Wade S. Smith, MD, PhD Submitted, 2010.

Internal Carotid Artery Thrombosis after Blunt Trauma – Salvage Therapy with the Penumbra Thrombectomy System. Rader M, Ramsay P, Maxwell R, Baxter B., *American Surgeon* 2010; 76(3): 343-345.

Arteriovenous Fistula and Pseudoaneurysm of the Posterior Tibial Artery after Calcaneal Slide Osteotomy: A Case Report. Jesse F Doty, Richard G Alvarez, Brandon S Asbury, Joseph N Rudd and William B Baxter *Foot Ankle International* 31(4):329-32 (2010).

Comparison of Selected Stretch Positions of the Piriformis Muscle Using Computerized Tomography and Biomodeling: a Pilot Study. Marcellin-Little D, Tillman LJ, Levine D, Baxter B, Andrews J, Wells H, *Journal of Orthopaedic and Sports Physical Therapy* 2009:39(1);A26-27.

The Merci Retrieval System for Acute Stroke: The Southeast Regional Stroke Center Experience. Devlin, T., Baxter, B., Feintuch, T., Desbiens, N., *Neurocritical Care*, 06:11-21, 2007.

Monitoring Cerebral Perfusion After Subarachnoid Hemorrhage Using CT. Nabavi, D.G., LeBlanc, L.M., Baxter, B., Lee, D.H., Fox, A.J., Lownie, S.P, Ferguson, G.G., Craen, R.A., Gelb, A.W., Lee, T.Y., *Diagnostic Neuroradiology* (2001) 43:7-16.

Endovascular Treatment of a "Blister-like" Aneurysm of the Internal Carotid Artery. P. D. McNeely, D.B. Clarke, B. Baxter, I. Mendez, *The Canadian Journal of Neurological Sciences*, Vol. 27, No. 3, 247-250, August 2000.

Double Microcatheter Technique for Detachable Coil Treatment of Large, Wide-Necked Intracranial Aneurysms. B.W. Baxter, D. Ross, S.P. Lownie, *American Journal of Neuroradiology*, 19:12176-1178, June 1998.

Abstract Publications:

"Measuring MERCI: exploring data mining techniques for examining the neurologic outcomes of stroke patients undergoing endo-vascular therapy at Erlanger Southeast Stroke Center." McNabb M, Cao Y, Devlin T, Baxter B, Thornton A. Annual International Conference of the IEEE Engineering in Medicine and Biology Society 2012. Abstract published in Engineering in Medicine and Biology Society (EMBC), 2012 Annual International Conference of the IEEE. 2012 August 28 – September 1. Pages 4704 – 4707.

"Thrombectomy for Acute Ischemic Stroke Patients Aged 80 Years or Older: Long-term Outcomes in 178 Patients." Nogueira RG, Smith WS, Jovin T, Liebeskind DS, Budzik RF, Baxter B, Rymer MM, Platform presentation at International Stroke Conference, February 25, 2010, Abstract published in *Stroke*. 2010 Apr; 41(4):e227.

"Neither Time to Treatment Nor the Use of Adjunctive Intra-arterial Thrombolytics Increase the Risk for Symptomatic Intracranial Hemorrhage After Endovascular Treatment of CT Perfusion or MRI-Selected Stroke Patients Treated at Late Time Windows: Analysis of the Pre-DAWN Dataset." Nogueira RG, Gupta R, Liebeskind DS, Rymer MM, Barreto AD, Levy AI, Zaidat OO, Rai A, Baxter B, Jovin T. 35th International Stroke Conference (San Antonio, TX – February 2010). Abstract published in Stroke. 2010 Apr;41(4):e227.

Presentations:

11th Annual SNIS/Joint Cerebrovascular Section Fellows Course, "Negotiating with the Hospital," Colorado Springs, Colorado, August 1, 2014.

SNIS 11th Annual Meeting, "DAWN Trial SNIS Investigator Meeting Presentation," Colorado Springs, Colorado, July 28, 2014.

11th Asian Australasian Federation of Interventional and Theapuetic Neuroradiology, "Cost Saving with New Generation Coils in Treatment of Difficult DAVF and Anuerysm," Da Nang, Vietnam, March 27, 2014.

11th Asian Australasian Federation of Interventional and Theapuetic Neuroradiology, "Carotid Endarterectomy Versus Stenting: E.B.M. and Practices," Da Nang, Vietnam, March 26, 2014.

11th Asian Australasian Federation of Interventional and Theapuetic Neuroradiology, "IV rTPA and Intra-Arterial Intervention in Ischemic Stroke: Indication and Result," Da Nang, Vietnam, March 26, 2014.

SNIS presents, "Stroke Summit 2014: Excellence in Patient Care," Chattanooga, Tennessee, March 19, 2014.

4th SNIS International Endovascular Stroke Conference and Joint Cerebrovascular Section Annual Meeting, "U.S. ADAPT Experience: A Direct Aspiration First Pass Technique for Acute Stroke Thrombectomy," San Diego, California, February 11, 2014.

Erlanger Medical Center, "Stroke Treatment," Chattanooga, Tennessee, January 28, 2014.

Foothills Medical Centre, "Growing Pains of a Busy U.S. Stroke Center: The Erlanger Experience," Calgary, Alberta, Canada, November 14, 2013.

Stop Stroke Saturday, Chattanooga, Tennessee, September 14, 2013.

Trevo Pro Vue Retrieval System Lab Training Course, "Procedural Set Up and Recommendations and Patient Case Experiences," Atlanta, Georgia, May 1, 2013.

Cardiac Symposium Seminar, "Innovations in Stroke Treatments," Ringgold, GA, February 21, 2013

3rd SNIS International Endovascular Stroke Conference and Joint Cerebrovascular Section Annual Meeting, "Ischemic Stroke and Hemorrhagic Cases," Honolulu, Hawaii, February 5, 2013

3rd SNIS International Endovascular Stroke Conference and Joint Cerebrovascular Section Annual Meeting, "Lunch Symposium," Honolulu, Hawaii, February 5, 2013

3rd SNIS International Endovascular Stroke Conference and Joint Cerebrovascular Section Annual Meeting, "Stroke Intervention in the Posterior Circulation", Honolulu, Hawaii, February 2, 2013

"Stroke Intervention Development the Asia/Pacific Region," Stryker, San Jose, California, January 29 – 31, 2013

ABC/WIN Conference,"Initial Multi-center Clinical Experience with Treating Small (<5mm) Aneurysms with the Penumbra PC400 Large Volume Coil: Improving the Treatment of Small Aneurysms at 4 High Volume US Centers", Val d'Isere, France, January 16, 2013

ABC/WIN Conference, "Preliminary Experience with a New Micro Vascular Covered Plug for More Rapid Endovascular Vessel Occlusions and Flow Control", Val d'Isere, France, January 14, 2013

Covidien Neurovascular Fellows Course, "Advanced Stroke Treatment," Houston, TX, December 8, 2012

Covidien Neurovascular Fellows Course, "Practice Management," Houston, TX, December 6, 2012

Covidien National Sales Meeting, "Access and Thrombectomy Techniques for Stroke Intervention," Newport Beach, California, November 15 – 16, 2012.

Stryker, "Recent Advances in Stroke Intervention," St. Louis, Missouri, November 7 – 8, 2012.

Cerebral Vascular Meeting, Conjoint Event of HKSITN and HKSS, "Evidence-based Strategies for Acute Stroke Treatment," Hong Kong, China, October 20, 2012.

Cerebral Vascular Meeting, Conjoint Event of HKSITN and HKSS, "Building a Stroke Centre," Hong Kong, China, October 20, 2012.

12th Advanced Neuroradiology Course, National Neuroscience Institute, "Recent Advances in Stroke Intervention," Singapore, October 18, 2012.

NEIMS 2012, "Coil Trials: Have We Learned Anything New?" Las Vegas, NV, September 23, 2012

NEIMS 2012, "Case Management Session", with Blaise Baxter, MD, M. Shazam Hussain, MD, Philip Meyers, MD and Michael Alexander, MD, Las Vegas, NV, September 23, 2012

NEIMS 2012, "Panel: the Future of Intracranial Stenting; East Meets West", Panel Discussion with Wei-Jian Jiang, MD, PhD, Peter Rasmussen, MD, Jian-Min liu, MD, Michael Alexander, MD, Simon Yu, MD and Blaise Baxter, MD, Las Vegas, NV, September 22, 2012

NEIMS 2012, "Transplanting Best Practices: Opening a Stroke Center in Vietnam", Las Vegas, NV, September 21, 2012

NEIMS 2012, Moderator, "Creating & Sustaining Continuum of Care for Stroke", Las Vegas, NV, September 21, 2012

NEIMS 2012, "Neuro-interventional Therapeutic Advances", Las Vegas, NV, September 21, 2012

Co-Moderator, Advanced Stroke Treatment Summit, Covidien
Chicago, IL, September 18-19, 2012
New York, NY, June 26-27, 2012

Society of NeuroInterventional Surgery Fellows Course 2012, "Stroke Treatment", San Diego, CA, July 27, 2012

Society of NeuroInterventional Surgery Meeting, "Clinical Experience and Lessons Learned with the Penumbra PC 400 Large Volume Coil: Improving the Treatment of Both Large and Small Aneurysms," San Diego, CA, July 2012.

"Stroke Access" Live Stroke Webinar sponsored by Covidien, Chattanooga, Tennessee, June 6, 2012.

Penumbra Fellows Meeting 2012, "Integrating New Technology into a Private Neuroradiology Practice", San Francisco, CA, March 2, 2012

Stryker Neurovascular Global Sales Meeting, "Acute Ischemic Stroke – Growing Endovascular Stroke Care", San Francisco, CA, February 15, 2012

Principal Lecturer, National Stroke Intervention Training Center, Introduction to Neurointerventional Procedures Workshop:
February 13 – 17, 2012
December 12-16, 2011
April 11-15, 2011
October 11-15, 2010
April 26-30, 2010
February 8-12, 2010
January 18-22, 2010
September 14-19, 2009
March 2-6, 2009

ABC-WIN Seminar, "Clinical Experience and Lesions Learned with the Penumbra PC400 Large Volume Coil: Improving the Treatment of both Large and Small Aneurysms", Val d'Isere, France, January 18, 2012

China Neuro-Interventionalists Conference (CNIC) 2011, "Mechanical Thrombectomy of BAO," Zhengzhou, China, October 30, 2011

NEIMS (New Era International Multidisciplinary Sharing) 2011, "Mechanical Thrombectomy of BAO," Zhengzhou, China October 27 - 28, 2011

Queen Mary Hospital and Tuen Men Hospital, "State of the Art Stroke Intervention," Hong Kong, October 24, 2011

13th Singapore Stroke Conference, "State of the Art Stroke Intervention," "Challenging Stroke Intervention Cases," Singapore, October 21 – 22, 2011

Penumbra Early Experience Roundtable (PEER) Meeting, "Penumbra Coil and Penumbra System for Treatment of Stroke", Chicago, IL, September 30 – October 1, 2011

NeuroNext National Symposium, "Clinical Management of AIS," San Jose, CA, October 2011

Vietnam Medical Congress, "Advanced Techniques in Neurointervention for Treatment of Stroke and Neurovascular Diseases", "Current Stroke Management at Erlanger Stroke Center", Ho Chi Minh City, Vietnam, July 2011

SNIS 2nd Annual Fellows Course, "Stroke Treatment – How I Do It", "Challenging Stroke Cases", Colorado Springs, CO, July 29, 2011

SNIS Annual Meeting, "Live Aneurysm Case Presentations," "A Discussion of New Techniques", "Challenging Stroke Cases", Colorado City, CO, July 28, 2011

SNIS Practicum, "Didactics Sessions: Stump the Expert," Seattle, Washington, June 5, 2011

SNIS Practicum, "Demonstration: Merci," Seattle, Washington, June 4, 2011

Penumbra Early Experience Roundtable (PEER) Dinner – "A Discussion of New Techniques with the Penumbra system and Early Experience with the Penumbra Coil 400", Washington, DC, May 10, 2011

Chattanooga Area 60th Annual Cardiac Symposium, "Innovations in Stroke Care", Chattanooga, TN, April 2011

Sanctuary of Endovascular Therapy, "High Volume Stroke Center Partnered with Peripheral Vascular Interventionalist: How to Work Together", Kiawah, SC, February 26, 2011

CLOTS, "Overview of Evidence for Intra-Arterial Pharmacomechanical Therapy", "Intra-Arterial Pharmacomechanical Therapy – How I do It", Dallas, TX, October 24-28, 2010

New Era International Multidisciplinary Sharing (NEIMS) Conference, A Focus on Acute Ischemic Stroke, "Tips and Tricks with Merci Devices", "Stroke Case Management: Panel Discussion", "Stroke Center Model 2: Chattanooga", Las Vegas, NV, October 2010

Australian and New Zealand Society of Neuroradiology and Asian-Australian Federation of Interventional and Therapeutic Neuroradiology, "Current Status and Role in Acute Stroke Management: Experience in a Large Stroke Centre", "State of the Art Stroke Treatment", Melbourne, Australia, April 24, 2010

CLOTS, "Overview of Evidence for Intra-arterial Pharmacomechanical Therapy", "Intra-arterial Pharmacomechanical Therapy – How I do It", Dallas, TX, December 6-10, 2009

2009 Vascular Access Conference, "Complicated Vascular Access Cases", Chattanooga, TN, August 27, 2009

SNIS Annual Meeting "Does Anesthesia Influence Clinical Outcomes in Mechanical Embolectomy? Real World Data from the Merci Registry", Boca Raton, FL, July 2009

Presented to United States President, George W. Bush, "Emerging Treatments for Acute Stroke", Southeast Regional Stroke Center at Erlanger Hospital, Chattanooga, TN, February, 2007

2nd Annual National Tutorial on Stroke, "Endovascular Treatment for Acute Stroke", Chicago, Illinois, June 3-5, 2005

Moderator, Concentric Physician Users Stroke Training Workshop:
Cleveland, Ohio, October 23, 2010
Newport Beach, Virginia, June 5, 2010
Atlanta, Georgia, May 8, 2010
Chicago, Illinois, March 6, 2010
Chicago, Illinois, September 19, 2009
Las Vegas, Nevada, April 24, 2009
Sydney, Australia, February 14, 2009
New Orleans, Louisiana, February 13, 2008
New York, New York, October 12 – 13, 2007
Chicago, Illinois, June 10, 2007
New York, New York, May 11, 2007
San Francisco, California, February 6, 2007
Miami, Florida, March 10, 2006
Las Vegas, Nevada, November 12, 2005
Chicago, Illinois, June 4, 2005
Toronto, Canada, May 20, 2005

Tutorial in Peripheral Vascular Interventional, "Carotid Artery Disease: Indications for Revascularization and Stenting Technique", Erlanger Health System, Chattanooga, TN, May 13-14, 2005

5th Annual Chattanooga Stroke Treatment Conference, "New Endovascular Treatment for Acute Stroke", Chattanooga, TN, November 6, 2004

65th Educational Conference of the Tennessee Society of Radiologic Technologists, Chattanooga, TN, October 16, 2003

Erlanger Healthy Heart Community Lecture Series, "What are my treatment options for intracranial artery disease?", UT Family Practice Center, Chattanooga, TN, August 8, 2002

Neurosurgery in the Caymans, "Endovascular Treatment of Cerebrovascular Disease", "GDC Coil Embolization of Intracranial Aneurysms; New Materials and Techniques", "Joint Ventures between Neurosurgeons and Interventional Neuroradiologists: The Nuts and Bolts", Cayman Islands, October 17 – 21, 2001

The Neuro Course
GDC Guglielmi Coils and AVMs – Embolization and Crazy Glue
Erlanger Health System, Chattanooga, Tennessee, 2000, 2001

Interventional Radiology Option, "Stroke Prevention and Treatment" Cumberland Medical Center, Crossville, Tennessee, October 2000
Atlantic Provinces Radiology Conference, "Head CT – The Good, The Bad, and the Ugly", Halifax, NS, October 1998
Atlantic Clinical Neurosciences Meeting, "Endovascular Treatment of Intracranial Aneurysms", Halifax, NS, April 1997

Neurosciences Grand Rounds, Halifax, NS

Ophthalmology Grand Rounds, Halifax, NS
Anesthesiology Grand Rounds, Halifax, NS

ICU and Neurosurgical Nurses CME Lecture, Halifax, NS

Saint John Regional Hospital Radiology/Neurosciences Group, Saint John, NB

American Society of Neuroradiology 35th Annual Meeting, "A Convenient Method for Cerebral Blood Flow Measurement: Dynamic CT Evaluation of Perfusion Parameters", Toronto, Ontario, May 1997

University of Western Ontario Neurosciences Research Day, June 1997

Radiology Grand Rounds – Dalhousie University, Halifax, NS

American Roentgen Ray Society 98th Annual Meeting, San Francisco, CA, April 1998

Dr. John Connelly's Dalhousie University Graduate Students' Neurosciences Course

Atlantic Provinces Radiology Conference, "Imaging Degenerative Disc Disease", Halifax, NS, October 1995

Atlantic Neurosciences Meeting, "Imaging Carotid Disease", Halifax, NS, April 1995

Atlantic Provinces Radiology Conference, "Helical CT – Imaging Strategies", Halifax, NS, October 1993

Abstract / Poster Presentations

"DAWN. DWI or CTP Assessment with Clinical Mismatch in the Triage of Wake Up and Late Presenting Strokes Undergoing Neurointervention," Jovin T, Jahans C, Saver J, Berry S, Lewis R, Lees K, Furlan A, Baxter B, Lutsep H, Ribo M, Jansen O, Gupta R, Mendes-Pereira V, Albers G, Smith W, Nogueira R. Presented at XXIII European Stroke Conference, Nice, France, May 6-9, 2014.

"A Utility-Weighted Modified Rankin Scale: Derivation and Application to Completed Stroke Trials," Chaisinanunkul N, Saver J, Jovin T, Berry S, Lewis R, Lees K, Furlan A, Baxter B, Lutsep H, Ribo M, Jansen O, Gupta R, Pereira-Mendes V and Nogueira R. Presented at American Academy of Neurology 66th Annual Meeting at the Pennsylvania Convention Center, Philadelphia, PA, April 30, 2014.

"Initial Multi-Center Experience with the Penumbra PC 400 Detachable Coil," Patel A, Moyle H, Chaudry I, Frei D, Bellon R, Huddle D, Baxter B, Quarfordt S, Turner R, Turk A. Presented at SNIS Meeting, Miami, Florida, July 2013.

"Initial Multi-Centre Experience with the Penumbra PC 400 Detachable Coil in Aneurysms 10mm or Greater," Chaudry I, Frei D, Baxter B, Patel A, Huddle D, Loy D, Moyle H, Polykarpou M, Patel A, Turner R, Turk A. Presented at SNIS Meeting, Miami, Florida, July 2013.

"Initial Multi-center Clinical Experience with Treating Small (<5mm) Aneurysms with the Penumbra PC400 Large Volume Coil: Improving the Treatment of Small Aneurysms at 4 High Volume US Centers", Blaise Baxter, Steve Quarfordt, Aman Patel, Henry Moyle, Aquilla Turk, Imran Chaudry, Ray Turner, Don Frei, Dan Huddle, Rich Bellon. Presented at SNIS Meeting, Miami, Florida, July 2013.

David S Liebeskind, Reza Jahan, Raul G Nogueira, Osama O Zaidat, Jeffrey L Saver, and for the SWIFT Investigators. Impact of Collaterals on Successful Revascularization in SWIFT. Stroke. 2013;44:A57. Presented at the International Stroke Conference. Honolulu, Hawaii. February 6-8, 2013.

David S Liebeskind, Reza Jahan, Raul G Nogueira, Tudor G Jovin, Helmi L Lutsep, Jeffrey L Saver, and for the SWIFT Investigators. Serial ASPECTS from Baseline to 24 Hours in SWIFT: A Novel Surrogate Endpoint for Revascularization in Acute Stroke. Stroke. 2013;44:ATMP17. Presented at the International Stroke Conference. Honolulu, Hawaii. February 6-8, 2013.

David S Liebeskind, Reza Jahan, Raul G Nogueira, Tudor G Jovin, Helmi L Lutsep, Jeffrey L Saver, and for the SWIFT Investigators. SWIFT! Early Presentation is Associated with Better Collaterals, Smaller Established Infarcts, and Better Clinical Outcomes from Endovascular Recanalization. Stroke. 2013;44:A130. Presented at the International Stroke Conference. Honolulu, Hawaii. February 6-8, 2013.

Reza Jahan, David Liebeskind, Raul Nogueira, Jeffrey Saver, and for SWIFT Investigators. TICI Success Rates In Swift: Comparison Between Randomized Arms And Correlation To 90 Day Neurologic Outcome. Stroke. 2013;44:A163. Presented at the International Stroke Conference. Honolulu, Hawaii. February 6-8, 2013.

Reza Jahan, David Liebeskind, Raul Nogueira, Jeffrey Saver, and for SWIFT Investigators. Revascularization Endpoints in SWIFT. Stroke. 2013;44:ATMP3. Presented at the International Stroke Conference. Honolulu, Hawaii. February 6-8, 2013.

Osama Zaidat, Marc A Lazzaro, Scott Brown, Raul G Nogueira, Rishi Gupta, Tudor Jovin, Tudor Jovin, Adnan Siddiqui, Dileep Yavagal, Reza Jahan, Jeffrey Saver, and For the Swift Investigators. How Long is Too Long: The Effect of Thrombectomy Procedure Duration on Outcome in Revascularized SWIFT Trial Patients. Stroke. 2013;44:ATP4. Presented at the International Stroke Conference. Honolulu, Hawaii. February 6-8, 2013.

"Blood Pressure Variation Associated with Emergent Intubation and During Endovascular Treatment in Acute Stroke Patients," Thomas Devlin, Francis Fesmire, Erlanger Health System, Chattanooga, TN; Wade Smith, Univ of California, San Francisco, San Francisco, CA; Jeffrey Shapiro, Piedmont Hosp, Atlanta, GA; Justin Jones, Blaise Baxter, Erlanger Health System, Chattanooga, TN. Presented as electronic poster at International Stroke Conference in Honolulu, Hawaii, February 1, 2013.

"Initial Multi-center Clinical Experience with Treating Small (<5mm) Aneurysms with the Penumbra PC400 Large Volume Coil: Improving the Treatment of Small Aneurysms at 4 High Volume US Centers", Blaise Baxter, Steve Quarfordt, Aman Patel, Henry Moyle, Aquilla Turk, Imran Chaudry, Ray Turner, Don Frei, Dan Huddle, Rich Bellon. Presented as oral poster at ABC/WIN Conference in Val d'Isere, France, January 16, 2013

"Preliminary Experience with a New Micro Vascular Covered Plug for More Rapid Endovascular Vessel Occlusions and Flow Control", Blaise Baxter, Satoshi Tateshima, David Niemann, Shaye Moskowitz. Presented as oral poster at ABC/WIN Conference in Val d'Isere, France, January 14, 2013

Saver JL, Jahan R, Levy EI, Jovin TG, Baxter B, Nogueira R, Clark W, Budzik R, Zaidat OO, for the SWIFT Trialists. Comparison of Solitaire FR and Merci Retriever Among MCA Acute Ischemic Stroke Patients in the SWIFT Multicenter, Randomized Trial. Presented at the 8th World Stroke Congress. Brasilia, Brazil. October 10-13, 2012.

Saver J, Jahan R, Levy E, Jovin T, Baxter B, Nogueira R, Clark W, Budzik R, Zaidat OO; for the SWIFT Trialists. Pooled analysis of roll-in and randomized patients in SWIFT confirms benefit of solitaire thrombectomy in patients with acute ischemic stroke. J Neurointerv Surg. 2012; 4 (Suppl 1) : A10-A11. Presented at the Society of NeuroInterventional Surgery (SNIS) 9th Annual Meeting, San Diego, California, USA. July 23-26, 2012.

"Clinical Experience and Lessons Learned with the Penumbra PC 400 Large Volume Coil: Improving the Treatment of Both Large and Small Aneurysms", Blaise Baxter and Steven Quarfordt. Presented as oral poster at SNIS 9th Annual Meeting in San Diego, CA, July 22 – 26, 2012.

"Putting the 'Eye' in I.V. Access – Unconventional Approaches in head and Neck Intervention", Blaise Baxter, Michael Mayich, John Hungerford. Presented as e-poster at SNIS 9th Annual Meeting in San Diego, CA, July 22-26, 2012.

"Wingspan Stent for Symptomatic Intracranial Stenosis: a Single Center Analysis", Baxter, B., Quarfordt, S., Hunger, J., Kline, A., Maass, G., Huang, X. Presented as e-poster at SNIS 9th Annual Meeting in San Diego, CA, July 22 - 26, 2012.

"Review of Penumbra System Trials: Low Rate of Embolization of Previously Uninvolved Territory of the Brain Using the Penumbra System in Acute Ischemic Stroke Treatment", Blaise Baxter. Presented as oral poster at SNIS 9th Annual Meeting in San Diego, CA, July 22 - 26, 2012.

"Comparison of SOLITAIRE Flow Restoration Device and the MERCI Retriever among Acute Ischemic Stroke Patients with Artrial Fibrillation in the SWIFT Multicenter, Randomized Trial", Saver, J., Jahan, R., Levy, E. Jovin, T., Baxter, B., Nougeira, R., Clark W., Budzi R., Zaidat O., for the SWIFT Trialists. Presented as oral poster at SNIS 9th Annual Meeting in San Diego, CA, July 22-26, 2012.

Saver J, Jahan R, Levy E, Jovin T, Baxter B, Nogueira R, Clark W, Budzik R, Zaidat OO; for the SWIFT Trialists. Solitaire Flow Restoration device versus the Merci Retriever in acute ischemic stroke: Subgroup and sensitivity analysis of the SWIFT multicenter, randomized trial. Cerebrovasc Dis 2012; 33 (suppl 2) pg 131. Presented at the European Stroke Conference. Lisbon, Portugal. May 22-25, 2012.

"Loose Screws: A Rare Complication of Repaired Cavernous Carotid Aneurysm", Dimple Bosu, Bradley Keel, Blaise Baxter, Victor Kolade. Presented at 2012 Southern Society of General Internal Medicine meeting in New Orleans, LA, February 10, 2012.

"Blood Pressure Variation Associated with Emergent Intubation and During Endovascular Treatment in Acute Stroke Patients", Thomas Devlin, Francis Fesmire, Wade Smith, Jeffrey Shapiro, Justin Jones, Blaise Baxter, Presented at International Stroke Conference, New Orleans, LA, February 1, 2012.

"An Uncommon Cause for a Common Symptom Complex", Nikhil Panda, Blaise Baxter, Steve Quarfordt, Bruce Faerber, Keith Woodward, Presented at Tennessee American College of Physicians meeting, October 13, 2011, Awarded second prize.

"Imaging Based Intraarterial Treatment for Acute Anterior Circulation Ischemic Stroke Due to Intracranial Large Vessel Occlusion Beyond 8 Hours from Symptoms Onset - Preliminary Multicenter Experience", Jovin TG, Gupta R, Liebeskind DS, Levy E, Rai A, Barreto A, Zaidat O, Janjua N, Abou-Chebl A, Yavagal D, Rymer M, Baxter B, Nogueira RG, 61st Annual Meeting of the American Academy of Neurology, Seattle, WA, April 2009.

"Preliminary Data for the DAWN Trial (DWI/PWI and CTP Assessment in the Triage of Wake-Up and Late Presenting Strokes Undergoing Neurointervention): Imaging Based Endovascular Therapy for Proximal Anterior Circulation Occlusions Beyond Eight Hours from Last Seen Well in 193 Stroke Patients", Raul Noguiera, David Liebeskind, Rishi Gupta, Elad Levy, Ansar Rai, Andrew Barreto, Osama Zaidat, Nazli Janjua, Brooklyn, Alex Abou-Chebl, Dileep Yavagal, Marilyn Rymer, Blaise Baxter, Anthony Furlan, Tudor Jovin, Presented as an oral platform during the stroke/interventional neurology section of the 61st American Academy of Neurology meeting in Seattle, WA 2009, Society of Neuro-Interventional Surgery meeting in Boca Raton, FL 2009, and 34th International Stroke Conference in San Diego, CA, February 2009.

"Imaging Based Intraarterial Treatment for Acute Anterior Circulation Ischemic Stroke Due to Intracranial Large Vessel Occlusion Beyond 8 Hours from Symptoms Onset - Preliminary Multicenter Experience", Jovin TG, Gupta R, Liebeskind DS, Levy E, Rai A, Barreto A, Zaidat O, Janjua N, Abou-Chebl A, Yavagal D, Rymer M, Baxter B, Nogueira RG, 61st Annual Meeting of the American Academy of Neurology, Seattle, WA, April 2009.

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meeting in Boca Raton, FL 2009, and 34th International Stroke Conference in San Diego, CA, February 2009.

"Internal Carotid Artery Thrombosis after Blunt Trauma – Salvage Therapy with the Penumbra Thrombectomy System", Rader M, Ramsay P, Maxwell R, Baxter B., Southeastern Surgical Congress, February 7-10, 2009, Atlanta, GA (presented by M Rader).

"Successful Thrombectomy in Acute MCA Stroke in a 13 y/o Child Using the MERCI Retrieval System", Baxter, B., Devlin, T.,Talbott, G.A., Varghese, S.S., Connell, B., Johnson, J., Society for Neuro-critical Care meeting, Abstract, Program 85, 2007.

"Utilization of the Merci Retrieval System for Acute Ischemic Stroke: The Chattanooga Regional Stroke Center Experience", B. Baxter; T. Devlin, et al., Society of Neuro-critical Care, November, 2006.

"Acute Thoracic Aortic Injury (ATAI): Experience with Helical CT", Martin Simms, MD, C.M. Richart, B.W. Baxter, J.T. Johnston, American Roentgen Ray Society, 100th Annual Meeting, Washington, D.C., May 7-12, 2000.

"A Convenient Method for Cerebral Blood Flow Measurement: Dynamic CT Evaluation of Perfusion Parameters", G.A. Joy, B.W. Baxter, T.Y. Lee, A.J. Fox, D.H. Lee, S.P. Lownie, G.G. Ferguson, R.A. Craen, A.W. Gelb, R.F. Del Maestro, American Roentgen Ray Society, 1998 Annual Meeting.

Scientific Presentations:

Primary Results of the SOLITAIRE™ With the Intention for Thrombectomy (SWIFT) Multicenter, Randomized Clinical Trial.
Jeffrey Saver, Reza Jahan, Elad Levy, Tudor Jovin, Blaise Baxter, Raul Nogueira, Wayne Clark, Ronald Budzik, Osama Zaidat. Presented as an oral platform at International Stroke Conference, New Orleans, LA, February 1, 2012.

Canadian Interventional Radiological Society Annual Meeting "Re-Treading Old Ground – Direct access of the Vertebral Artery". Podium Presentation (Residents' and Fellows' Section).
Presenter Mayich M, Vancouver, Canada, 2012.

CT Perfusion Imaging in the Selection of Hyperacute Stroke Patients to Undergo Emergent Carotid Endarterectomy.
Sachin V Phade, MD, (Presenting), Mark W Fugate, MD, Grant R Major, MD, R K Hutson, MD, Steven D Quarfordt, MD, Blaise W Baxter, MD, Thomas G Devlin, MD. Presented at Peripheral Vascular Surgery Society 22nd Annual Winter Meeting, Vail, CO, January 28, 2012.

Incidence of Catheter-induced Clot Formation in Acute Ischemic Stroke Patients Undergoing Mechanical Thrombectomy: Is Pre-procedure Intravenous Heparin Bolus Necessary?
J.B. Crudup, MD, B.I. Hartley, MD, B.W. Baxter, MD. Presented as an oral platform at Radiology Society of North America meeting, Chicago, IL, 2011.

Epidural Blood Patch for Spontaneous Cerebrospinal Fluid Leak.
Arlene Richardson, MD and Blaise Baxter, MD. Presented as an oral platform at the National Medical Association's 2010 Annual Convention & Scientific Assembly, August 2010, Orlando, FL.

Successful Thrombectomy in Acute MCA Stroke in a 13 Y/O Child Using the MERCI Retrieval System.
Talbott, G.A., Verghese, S.S., Connell, B., Johnson, J., Baxter, B., and Devlin, T.G., Presented at: Neurocritical Care Society 5th Annual Meeting, November 2-3, 2007 (Abstracts: Oral & Presentations) Las Vegas, NV.

Utility of CT Myelography in Spontaneous Intracranial Hypotension.
A.M. Andeejani, Vandorpe, W.J. Maloney, B. Baxter, G.C. Llewellyn, R. Holness, Presented at: American Society of Head and Neck Radiology, Phoenix, Arizona, March 1998, Canadian Association of Radiologists Annual Meeting, Halifax, NS, June 1998.

Anomalous Orbital Venous Drainage of Intracranial Veins.
A.M.I. Andeejani, W.J. Maloney, R. Vandorpe, B.Baxter, G. Llewellyn, D.B. Clarke, Presented at: American Society of Neuroradiology 36th Annual Meeting, Philadelphia, PA, May 1998.

The Role of CT Myelography and Delayed CT Myelography in the Management of Spontaneous Intracranial Hypotension: New Sign of Spontaneous Hypotension Preimposed Treatment.
A.M.I Andeejani, R. Vandorpe, W.J. Maloney, B. Baxter, G. Llewellyn, R. Holness, Presented at: American Society of Neuroradiology 36th Annual Meeting, Philadelphia, PA, May 1998.

Anomalous Intracranial Venous Drainage into the Orbit in a Patient with Extensive Cerebral Development Venous Anomalies.
A.M.I. Andeejani, W.J. Maloney, R. Vandorpe, B. Baxter, C.G. Llewellyn.
Presented at: Canadian Association of Radiologists Annual Meeting, Halifax, NS, June 1998.

A Convenient Method for Cerebral Blood Flow Measurement: Dynamic CT Evaluation of Perfusion Parameter.
G.A. Joy, B.W. Baxter, T.Y. Lee, A.J. Fox, D.H. Lee, S.P. Lownie, G.G. Ferguson, R.A. Craen, A.W. Gelb, R.F. DelMaestro.
Presented at: American Society of Neuroradiology 35th Annual Meeting, Toronto, ON, May 1997. Canadian Association of Radiologists Annual Meeting, Halifax, NS, June 1998.

A Comparison of Length of Hospitalizations and Clinical Outcomes for DGC Embolization Vs Surgical Clipping of Anterior Communicating and Basilar Artery Aneurysms.
E. Versnick, B.Baxter, R. Vandorpe, W. Maloney, I. Mendez.
Presented at: 99th Annual ARRS Meeting, New Orleans (Exhibit & Presentation), 1999.
37th Annual American Society of Neuroradiology, San Diego, 1999.

Research / Clinical Trials (Principle Investigator):

The THERAPY Trial: The Randomized, Concurrent Controlled Trial to Assess the Penumbra System's Safety and Effectiveness in the Treatment of Acute Stroke

SWIFT-Solitaire FR with the Intention for Thrombectomy Study-IDE study sponsored by ev3 Neurovascular

ACE: An Aneurysm Coiling Efficiency Study of the Penumbra Coil 400 System

Stenting versus Aggressive Medical Management for Preventing Recurrent Stroke in Intracranial Stenosis (SAMMPRIS)

TREVO-Thrombectomy Revascularization of large Vessel Occlusions in acute ischemic stroke-IDE study sponsored by Concentric Medical

Reverse Medical ReStore Thrombectomy Device for Flow Restoration in Arteries of Patients Experiencing Acute Ischemic Stroke-IDE study sponsored by Reverse Medical

DEDAS Acute Ischemic Stroke Trial; thrombolytic; sponsored by PAION (Germany)

Interventional Management of Stroke Trial II, acute ischemic stroke trial, combined mechanical and thrombolytic; NIH

Interventional Management of Stroke Trial III, acute ischemic stroke trial; combined mechanical and thrombolytic; NIH

Multimedia

Fundamentals of Diagnostic Radiology; CD-ROM, Cupido Daniels – Chief Editor.

Find Shortage Areas: MUA/P by State and County

Shortage Designation Home
Find Shortage Areas
HPSA & MUA/P by Address
HPSA by State & County
HPSA Eligible for the Medicare Physician Bonus Payment

Criteria:

State: Tennessee
County: Bledsoe County
Bradley County
Grundy County
Hamilton County
McMinn County
Marion County
Meigs County
Polk County
Rhea County
Sequatchie County
ID#: All

Results: 34 records found.

Name	ID#	Type	Score	Designation Date	Update Date
Bledsoe County					
Bledsoe County	03175	MUA	58.40	1978/11/01	2014/05/21
Bradley County					
Cleveland Division Service Area	03253	MUA	43.20	1994/05/12	
MCD (90392) District 3					
MCD (90772) District 5					
MCD (90962) District 6					
MCD (91152) District 7					
Grundy County					
Grundy County	03194	MUA	51.50	1978/11/01	2014/05/21
Hamilton County					
Hamilton Service Area	03244	MUA	56.43	1982/06/03	1994/05/04
CT 0004.00					
CT 0006.00					
CT 0008.00					
CT 0011.00					
CT 0012.00					
CT 0013.00					
CT 0014.00					
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CT 0024.00					
CT 0025.00					
CT 0026.00					
CT 0031.00					
CT 0122.00					
CT 0123.00					
CT 0124.00					
McMinn County					
Mcminn Service Area	03211	MUA	57.00	1978/11/01	
Marion County					
Marion Service Area	03215	MUA	53.30	1978/11/01	
Meigs County					
Meigs County	03217	MUA	57.40	1978/11/01	2014/05/21
Polk County					
Turtletown Service Area	07498	MUA	57.30	1994/05/12	
MCD (90520) District 3					
Rhea County					
Rhea Service Area	03226	MUA	55.50	1978/11/01	
Sequatchie County					
Sequatchie Service Area	03230	MUA	54.30	1978/11/01	

NEW SEARCH MODIFY SEARCH CRITERIA

Origination Date:		
Approval:		
Reviewed Date:	Revised Date:	Ap
12/05		
	1/09	
5/11		
	6/12	
	1/13	

Erlanger Health System Policy and Procedure

Index Title: Emergency Response on Erlanger Baroness Campus
Originating Department: Administration
Number: 8316.951
Description for EHS Intranet: Emergency; Emergency Response; Off campus emergencies;

Policy statement: Erlanger Health System (EHS) provides this policy and process to determine who should respond when an emergency situation occurs on the Baroness Campus, and designated adjacent areas.

Scope: EHS employees within Baroness Campus.

Procedure:

When an emergency situation occurs within Baroness Campus / Miller Eye Center or any location on the ground or first floor of the Medical Mall, a Code Blue, Code 5 or Rapid Response call should be made.

Emergency situations that occur on adjacent grounds, e.g. driveways, parking lots, Whitehall Building, Fillauer Building, UT Family Practice, E kids, Lincoln Park Building and any area not described above should contact **911**. For additional medical expertise, the House Supervisor (HS) may be contacted.

Independent Physician Practices are not part of the Hospital and should be considered as adjacent grounds. For these areas, contact **911** in emergency situations.

The HS can be immediately contacted by dialing 778-6911. After assessing the nature of the emergency, while waiting for a response, the appropriate first aid care, CPR (Cardiopulmonary Resuscitation), containment of bleeding and/or comfort measures are to be offered. This care must be consistent with good medical practice (which may mean, "doing no harm" and not moving the person). The HS will determine the level of response required for emergency/medical situations after considering the following:

- Personal safety of the responding personnel.
- Availability of medically trained staff who could be dispatched to the location.
- Status/need of current and waiting patients, in that the medical care of these individuals will not be delayed or impaired by having emergency personnel dispatched to another location.

- Availability of portable medical equipment and supplies to be transported by emergency medical personnel to the location.

The Rapid Response Nurse (7789) may be called on to serve as the back up for the HS, should the HS be unavailable.

The HS will put the Emergency Department on stand-by for additional stabilizing and packaging equipment, including transport needs via stretcher.

See CPR Adult Code Blue Process, PC.120.
See CPR Pediatric Code 5 Process, 6012.08

Committee	Approval/Date
Legal	6/12
Code Committee	6/12

Medical Director	Approval/Date

References:

Erlanger Health System Policy and Procedure

Origination Date: 02/11/09		
Approval:		
Reviewed Date:	Revised Date:	Approval:
4/18/112/2013		7/2014

Index Title: Non-EmergentHospitalOutpatient Order Policy
Originating Department: Patient Access
Number: 8316.1035
Description for EHS Intranet: Outpatient Orders

Policy Statement: Erlanger Health System (EHS) requires a complete and valid physician outpatient order prior to non-emergent hospital services being rendered.

Purpose: To establish guidelines outlining the documentation required for all non-emergent outpatient services orders submitted in accordance with payer guidelines. This policy should be used in conjunction with the Non-Covered Services Policy and the Medical Necessity Policy.

Scope: All non-emergent outpatient services provided by an outpatient department of Erlanger Health System.

Exceptions: Exceptions to this policy applicable to Medicare patients include the following services for which Medicare does not require a documented order:

- Screening mammography;
- Pneumococcal pneumonia vaccine (PPV) and its administration;
- Influenza vaccine and its administration.

Definitions:

Authentication: The requirement of a written signature or a computer-secure entry by a unique identifier of a primary author who has approved the entry.

Advance Beneficiary Notice (ABN): An ABN is a written notice given to a Medicare Beneficiary before Part B services are furnished when Erlanger Health System believes that Medicare will not pay for some or all of the services on the basis that they are not reasonable and necessary (i.e., under §1862(a)(1) of the Act) and Erlanger Health System (EHS) wishes to bill the patient for the provided services. The information in the ABN will assist the beneficiary in making an informed decision whether or not to receive the service and be financially responsible for the payment.

Deferral of Hospital Outpatient Services: The deferral or re-scheduling of services until the receipt of a complete and valid physician order and the financial requirements being met.

Medical Necessity: Items or services which may be justified as reasonable, necessary, and/or

appropriate, based on evidence-based clinical standards of care.

Modification of Orders: Existing orders may not be changed by EHS personnel. Any change or addition to a service or test embodied in an existing order requires that the procedures noted in the "Modification of Outpatient Orders" section of this policy be followed.

Non-Physician Practitioner ("NPP"): An NPP can be a physician assistant, clinical psychologist, nurse practitioner, clinical nurse specialists, licensed clinical social worker, or certified nurse midwife acting within his/her state scope of practice laws and hospital-granted privileges.

Outpatient Laboratory Requisition: A computer generated document listing outpatient tests that are available for a Physician to order. It can serve as evidence of the services the Physician intended to order if it is also adequately documented in the medical record and authenticated.

Order Sets: An order that outlines a treatment regime or standard of care required for a patient having a specifically-defined type of care / treatment (i.e., AHCPR protocol for treatment of pressure ulcers). Special Note: Orders for outpatient services may be supported by a valid, approved hospital order set that has been initiated by a physician or NPP and approved by the hospital's Medical Staff. A copy of the order set must be maintained in the patient's medical records.

Recurring Orders:A physician may submit an order for tests, injections, lab, infusions, etc., to be performed on a recurring basis. The recurring order must include all elements as outlined in theoutpatient order elements noted below in this policy, including:

- Frequency of the test, etc. to be performed (such as monthly, weekly,bi-weekly, etc.)
- The length of time that the order is to re-occur and is valid(such as 6 weeks, 2 weeks, 3 months, etc.) Most will be updated every six months – however, a Recurring Order may be valid beyond 6 months or less / more than this time period based on time specifications of the physician as the duration of the patient's specific treatment period, not to exceed twelve months.
- Number of treatments to be provided (such as 10 HBO TX, etc.)
- Must be medically necessary

Treating physician: A physician, as defined in §1861 (r) of the Social Security Act (the Act), who furnishes a consultation or treats a beneficiary for a specific medical problem, and who uses the results of a diagnostic test in the management of the beneficiary's specific medical problem.

PROCEDURES:

The following are the required data elements for Non-Emergent Hospital Outpatient Orders:

1. Patient Legal Name;
2. Patient date of birth;
3. Reason for ordering the test or service (i.e., diagnosis description signs or symptoms);

4. Physician or qualified health professional authentication "signature";
5. Name of ordering practitioner;
6. Date of order (Date provider signed the order).

A complete and valid physician order contains the above elements. When the above elements are present and all other coverage guidelines are met, the hospital may provide and subsequently bill for the services ordered once performed.

Special Note: An acceptable order should not include such diagnosis language as:

- Rule/Out (R/O)
- Possible
- Suspicious
- Probable

A complete and valid physician order should be secured for all non-emergent outpatient services **at least 48 hours prior to the patient's date of service**by responsible registration and scheduling personnel.

All non-emergent outpatient services scheduled without a complete and valid order 48 hours prior to the patient's date of service will be escalated by Patient Access. The physician or physician's office personnel will be contacted via telephone and email notifying them that the service will be deferred due to the lack of a valid order. Once notified, the physician's office must supply a valid order that contains all of the required elements no later than 24 hours prior to scheduled appointment to prevent the service from being deferred and rescheduled.

Unscheduled or walk-in patients must arrive at registration with a complete and valid physician order. Patient Access, Registration or other responsible personnel receiving an incomplete order must call the physician office and request the required information. The physician office must furnish a new order for any unscheduled or walk-in patients arriving at registration without a complete and valid order prior to the services being provided. Unscheduled or walk-in patients may experience extended wait times pending receipt of a complete and valid order, verification of patient insurance policy requirements related to pre-certification or pre-authorization of services prior to services being rendered.

Every effort should be made to obtain all required information prior to services being rendered. For Medicare and Medicaid patients, the Center for Medicare & Medicaid Services guidelines state that if patient care or the integrity of a specimen is at risk, you should continue processing the test (s) or performing service (s) and subsequently obtain the required elements. This requires clinical judgment and should be discussed with appropriate supervisor(s).

All Patient Access registration departments are responsible for scanning the complete and valid physician order into HPF in order for the order to become a part of the patient's medical record.

If any of the required outpatient order data elements noted above are missing, a new order will be **REQUIRED** directly from the physician prior to the services being performed.

Verbal orders will notbe accepted for non-emergent hospital outpatient services.

Modification of Order:

As noted above, every effort should be made to obtain all required information prior to non-emergent outpatient services being provided. Patient Access, Registration or other personnel receiving an incomplete order must call the physician office and request that the physician office furnish a new and valid order prior to the services being provided.

If patient services were rendered with an incomplete order (i.e. missing or incorrect Dx),the physician can make an entry to clarify/correct this by amending the patient's medical record, documenting the missing data element and / or reason for the correction and providing us with a copy of the amended patient record. If an order for a clinical diagnostic service is missing the provider's authentication, you may rely on a copy of the patient's medical record if it already has documentation of the provider's intent to order the services and the medical record had beenpreviously authenticated. Please note that this should be the exception not the rule.

Implementation:

1. EHS must ensure all outpatient orders, whether paper-based or generated through web-based physician portals, meet the requirements of this policy.

2. EHS must have a process in place to ensure staff and Physicians are notified of the requirements of this policy.

Annual Review:

This policy and related supporting documents are subject to annual review by the Patient Access Department and members of the Revenue Cycle Committee, including the Office of Compliance.

Enforcement:

All EHS personnel whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Those employees who fail to comply with this policy will be subject to appropriate disciplinary action pursuant to EHS' applicable policy and procedure, up to and including termination.

Committee	Approval/Date

References:

Medicare Conditions of Participation
42 C.F.R §482.23; §428.24; §428.26b.4
42 C.F.R §410.32
TJC (The Joint Commission) RC standards
TJC (The Joint Commission) MS 2.5
http://www.cms.gov/Medicare/Coding/ICD10/index.html
CMS Benefit Policy Manual (Pub 100.02) Transmittal 80
CMS "Medicare Program Integrity Manual" (Publication [Pub.] (100-08), Chapter 3, Section 3.4. 11. D
CMS, State Operations Manual Appendix A-Survey Protocol, Regulations, and Interpretive Guidelines for Hospitals, Interpretive Guidelines §482.24(c) (1) (i) and (ii)
EHS Rules and Regulations of the Medical Staff (January 18, 2011)
EHS Bylaws of the Medical Staff (May 2010)
The ABN manual instructions and ABN Form CMS -R-131 are available at http://www.cms.gov/ BNI/02_ABN.asp

SIEMENS

Siemens Medical Solutions USA, Inc.
51 Valley Stream Parkway, Malvern, PA 19355
Fax: (866) 309-6967

SIEMENS REPRESENTATIVE
Karen Dixon - (865) 360-8644

PRELIMINARY PROPOSAL

Customer Number: 0000006071

Date: 9/3/2014

ERLANGER HEALTH SYSTEM
975 EAST THIRD STREET
CHATTANOOGA, TN 37403

Estimated Delivery Date: 1/31/2015

Estimated delivery date is subject to change based upon factory lead times, acceptance date of this quote, customer site readiness, and other factors. A Siemens representative will contact you regarding the final delivery date.

The FREEZEiT application is included in this MAGNETOM MRI system configuration, but will not be delivered until the system's operating software is upgraded to the next software version.

This quote is based upon standard delivery terms and conditions (e.g., standard work hours, first floor delivery, etc.), basic rigging, mechanical installation and calibration. Siemens Medical Solutions USA, Inc., Project Management shall perform a site-specific assessment to ascertain any variations that are out of scope and not covered by the standard terms (examples such as, but not limited to: larger crane, nonstandard work hours, removal of existing equipment, etc.). Any noted variations identified by Siemens Project Management shall remain the responsibility of the customer and will be subject to additional fees.

This offer is only valid if a firm, non-contingent order is placed with Siemens and a signed POS contract must accompany the equipment order.

The total value of the BioMed Training within this Quotation is $64,350.

This offer is only valid if firm, non-contingent orders Skyra Quote# 1-559QUR, Zee Ceiling Q# 1-91ZERR, and Zee Ceiling Q# 1-7M63QV are placed with Siemens and signed POS contracts accompany the equipment orders.

This Quotation is specific to ERLANGER HEALTH SYSTEM and contains information which is confidential and proprietary to Siemens, including but not limited to discounts and pricing. The Customer may not distribute or disclose this quotation or any portion hereof to, or discuss any of the information (including pricing) contained herein with, any other customer or consultant, buying group, or other third party.

Quote Nr: **1-559QUR Rev. 3**

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SIEMENS REPRESENTATIVE
Karen Dixon - (865) 360-8644

PRELIMINARY PROPOSAL

MAGNETOM Skyra

All items listed below are included for this system: *(See Detailed Technical Specifications at end of Proposal.)*

Qty	Part No.	Item Description
1	14418500	**MAGNETOM Skyra - System** MAGNETOM Skyra - 3T Tim+Dot system - the integration of the next generation Tim "Tim 4G" and Siemens unique Dot Engines (Day optimizing throughput Engines). Short and open appearance (173 cm system length with 70 cm Open Bore Design). Tim 4G with redesigned RF system and all-new coil architecture. DirectRF(tm) technology enabling Tim's new all digital-in/ digital-out design - All-new coil architecture including Dual-Density Signal Transfer Technology - Whole-body superconductive Zero Helium Boil-Off 3T magnet - TrueForm Magnet and Gradient Design - Actively shielded water-cooled Siemens gradient system - TimTX TrueForm for uniform RF distribution in all body regions - Head/Neck 20 DirectConnect, Spine 32 DirectConnect, Body 18, Flex Large/Small 4 Dot offers patient personalization, user guidance and process automation. Brain Dot Engine - personalized, guided and automated workflows - Dot Display and Dot Control Centers for efficient patient preparation. Additional features included: -Tim Application Suite including Neuro, Angio, Cardiac, Body, Onco, Breast, Ortho, Pediatric and Scientific Suite - syngo MR software including 1D/2D PACE, syngo BLADE, iPAT², Phoenix, Inline Technologies. - High performance host computer and measurement and reconstruction system The system (magnet, electronics and control room) can be installed in 31sqm space. For system cooling either the Eco Chiller options or the Separator is required.
1	14418502	**Tim [204x48] XQ Gradients #Sk** Tim [204x48] XQ-gradients performance level - Tim 4G's newly designed RF system and innovative coil architecture enables high resolution imaging and increased throughput. Up to 204 simultaneously connected coil elements, in combination with the standard 48 independent RF channels, allow for more flexible parallel imaging. Maximum SNR through the new Tim 4G matrix coil technolgy. XQ - gradients - The XQ - gradients - high performance and linearity to support clinical whole body imaging at 3T. The force compensated gradient system minimizes vibration levels and accoustic noise. The XQ gradients combine 45 mT/m peak amplitude with a slew rate of 200 T/m/s.
1	08464872	**PC Keyboard US english #Tim** Standard PC keyboard with 101 keys.
1	14416914	**Pure White Design #T+D** The MAGNETOM Aera / MAGNETOM Skyra design is available in different light and appealing variants which perfectly integrates into the different environments. The color of the main face plate cover of the Pure White Design Variant with the integrated Dot Control Centers and the unique Dot Display is brilliant white surrounded by a brilliant silver trim. The asymetrical deco area on the left side is colored white matte and also with a brilliant surrounding silver trim. The table cover is presented also in the same color and material selection.
1	14418507	**Tim Dockable Table #Sk** The Tim Dockable Table is designed for maximum patient comfort and smooth patient preparation. Tim Dockable Table can support up to 250 kg (550 lbs) patients without restricting the vertical or horizontal movement. The one step docking mechanism and the innovative multi-directional navigation wheel ensure easy maneuvering and handling. Critically ill or immobile patients can now be prepared outside the examination room for maximum patient care, flexibility and speed.
1	14430396	**Spine Dot Engine #T+D** The Spine Dot Engine provides optimized cervical, thoracic and lumbar spine imaging. Amongst various features to support streamlined spine workflow is Labeling of the vertebrae suggested by the system, Tim Planning Suite and In-line Composing. syngo WARP with View Angle Tilting (VAT) technique is provided for reducing in-plane geometric distortions syngo WARP can be used throughout the body.
1	14413612	**Tissue 4D syngo #Tim** Tissue 4D is an application for visualizing and post-processing dynamic contrast-enhanced 3D datasets. This card provides two evaluation options: - Standard curve evaluation - Curve evaluation according to a pharmacokinetic model

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PRELIMINARY PROPOSAL

Qty	Part No.	Item Description
1	MR_FREEZEIT	**Body MRI FREEZEit Package** MR_FREEZE BODY MRI - FREEZE IT Package FREEZEit Body Package contains two robust sequences for advanced body imaging: TWIST VIBE and StarVIBE. - TWIST VIBE is a new fast, high-resolution 4D imaging sequence for multi-arterial liver imaging. - StarVIBE is a motion insensitive VIBE sequence using a stack-of-stars trajectory. NOTE: This application package is contingent on the customer purchase of an EVOLVE Service contract for the scanner. Without an active EVOLVE Service Contract additional costs will be incurred for installation and activation of the application.
1	14430391	**RESOLVE #T+D** RESOLVE is a diffusion-weighted, readout segmented EPI sequence optimized towards high resolution imaging with reduced distortions. The sequence uses a very short echospacing compared to single-shot EPI, substantially reducing susceptibility effects. A 2D-navigator correction is applied to avoid artefactsartifacts due to motion-induced phase errors. This combination allows diffusion weighted imaging of the breast, prostate, brain and spinewhole body with a high level of detail and spatial precision.
1	14405224	**Composing syngo #Tim** This application provides dedicated evaluation software for creation of full-format images from overlapping MR volume data sets and MIPs (starting from syngo MR B13) acquired at multiple stages.
1	14418511	**Body 18 #Sk** The Tim 4G coil technology with Dual Density Signal Transfer and SlideConnect Technolgy combines key imaging benefits: excellent image quality, high patient comfort, and unmatched flexibility: - 18 channels (inherent) or up to 30 (in combination with the Spine 32) - Dual Density Signal Transfer - Ultra light-weight - SlideConnect Technology The Body 18 is part of the standard configuration. The 18-channel coil with its 18 intergrated pre-amplifiers ensures excellent signal-to-noise ratio. The 18 coil elements provide extensive coverage in all directions. The single SlideConnect plug allows for fast and easy patient preparation. The light-weight coil ensures highest patient comfort. The Body 18 Coil features: - 18-element design with 18 integrated preamplifiers (3 clusters of 6 elements each) - Operates in an integrated fashion with the Spine 32 as an 30 channel body coil - Can be combined with further Body 18 coils for larger coverage - Can be positioned in different orientations (0°, 90°, 180°, 270°) for patient specific adaptations - No coil tuning - iPAT compatible in all directions The highly flexible design enables a wide variety of applications including: - Thorax (incl. heart) - Abdomen - Pelvis - Hip Typically combined with: - Head / Neck 20 - Spine 32 - Additional Body 18 coil(s) (optional) - Peripheral Angio 36 (optional) - Flex Large 4 - Flex Small 4 - Loop 3T coils (optional) - Endorectal coil (optional)
1	14402527	**SWI #Tim** Susceptibility Weighted Imaging is a high-resolution 3D imaging technique for the brain with ultra-high sensitivity for microscopic magnetic field inhomogeneities caused by deoxygenated blood, products of blood decomposition and microscopic iron deposits. Among other things, the method allows for the highly sensitive proof of cerebral hemorrhages and the high-resolution display of venous cerebral blood vessels.
1	14416908	**Tim Whole Body Suite #T+D** Tim Whole Body Suite puts it all together. This suite enables table movement for imaging of up to 205 cm (6' 9") FoV without compromise. In combination with Tim's newly designed ultra highdensity array higher spatial and temporal resolution can be achieved along with unmachted flexibility of any coverage up to Whole Body. For faster exams and greater diagnostic confidence.
1	14405328	**TWIST syngo #Tim** This package contains a Siemens unique sequence and protocols for time-resolved (4D) MR angiographic and dynamic imaging in general with high spatial and temporal resolution. syngo TWIST supports comprehensive dynamic MR angio exams in all body regions. It offers temporal information of vessel filling in addition to conventional static MR angiography, which can be beneficial in detecting or evaluating malformations such as shunts. In case of general dynamic imaging, for example an increase in spatial resolution by a factor of up to 2 at 60 seconds temporal resolution (compared to conventional dynamic imaging) is possible due to intelligent k-space sampling strategies. Alternatively, increased temporal resolution at constant spatial resolution is possible.
1	14409198	**Native syngo #Tim** Integrated software package with sequences and protocols for non-contrast enhanced 3D MRA with high spatial resolution. syngo NATIVE particularly enables imaging of abdominal and peripheral vessels and is an alternative to MR angiography techniques with contrast medium, especially for patients with severe renal insufficiency.

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PRELIMINARY PROPOSAL

Qty	Part No.	Item Description
1	14416959	**Shoulder 16 Coil Kit #Sk** The new Tim 4G coil technology with Dual Density Signal Transfer and SlideConnect Technolgy combines key imaging benefits: excellent image quality, high patient comfort, and unmatched flexibility. The Shoulder 16 Coil Kit for examinations of the left or right shoulder consists of a base plate and two different sized iPAT compatible 16 channel coils (Shoulder Large 16 and Shoulder Small 16). These will be attached and can be relocated on the base plate.The 16-element coils with 16 integrated pre-amplifiers ensure maximimum signal-to-noise ratio. Shoulder Large 16 and Shoulder Small 16 will be connected via a SlideConnect plug for fast and easy coil set-up and patient preparation.
1	14418513	**Hand/Wrist 16 #Sk** The new Tim 4G coil technology with Dual Density Signal Transfer and SlideConnect Technology combines key imaging benefits: excellent image quality, high patient comfort, and unmatched flexibility. Hand/Wrist 16 for examinations of the left or right hand and wrist region consists of a base plate and an iPAT compatible 16-channel coil and allows high resolution imaging of the wrist and the hand within one examination. Hand/Wrist 16 will be connected via a SlideConnect plug for fast and easy patient preparation.
1	14418514	**Foot/Ankle 16 #Sk** The new Tim 4G coil technology with Dual Density Signal Transfer and DirectConnect Technolgy combines key imaging benefits: excellent image quality, high patient comfort, and unmatched flexibility. Foot/Ankle 16 for examinations of the left or right foot and ankle region consists of a base plate and an iPAT compatible 16-channel coil and allows high resolution imaging of the foot and ankle within one examination. Foot/Ankle 16 is a cable-less coil and will be connected via DirectConnect for fast and easy patient preparation.
1	14430404	**Tx/Rx 15-channel Knee Coil DDST #Sk** New 15-channel transmitter/receiver coil for joint examinations in the area of the lower extremities. Main features : - 15-element design (3x5 coil elements) with 15 integrated preamplifiers, - iPAT-compatible - SlideConnect Technology
1	14416904	**32-channel Head Coil #Sk** The 32-channel Head Array Coil is an iPAT-compatible "no-tune" receiver coil for MAGNETOM Skyra.
1	14426333	**Tx/Rx CP Head Coil #Sk** Circularly polarized no-tune transmit/receive coil with an open patient-friendly design. The integrated transmit mode allows volume selective excitation. Integrated, extremely low-noise pre-amplifiers permit very high signal-to-noise ratio. Furthermore, the coil is outfit with SlideConnect Technology, allowing for easier patient preparation and less table time for the patient. Furthermore, the coil is outfit with SlideConnect Technology, allowing for easier patient preparation and less table time for the patient.
1	14407258	**MR Workplace Table 1.2m** Table suited for syngo Acquisition Workplace and syngo MR Workplace based on syngo Hardware.
1	14407261	**MR Workplace Container, 50cm** 50 cm wide extra case for the syngo host computer with sliding front door to allow change of storage media (CD/DVD/USB).
1	08857828	**UPS Cable #Tim** Power cable for connecting the UPS Powerware PW 9130-3000i (14413662) to the ACC of MAGNETOM Tim and MAGNETOM Tim+Dot systems for backing up the computer. Standard cable length: 9 m.
1	14413662	**UPS Powerware PW9130G-3000T-XLEU** UPS system Eaton PW9130G-3000T-XLEU for MAGNETOM Tim, MAGNETOM Tim+Dot and MAGNETOM Symphony systems for safeguarding computers. Power output: 3.0 kVA / 2.7 kW Bridge time: 5 min full load / 14 min half load Input voltage: 230 VAC
1	14413663	**UPS Battery module** UPS battery module Eaton PW 9130N-3000T-EBM for all MAGNETOM Tim, MAGNETOM Tim+Dot and MAGNETOM Symphony systems for safeguarding computers. Extension for: PW9130i-3000T Battery type: Closed, maintenance-free Extension of the bridge time to: 24 minutes with a module Dimensions (H x W x D): Battery module: 346 x 214 x 412 mm incl. bracket set Weight: approx. 50 kg

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PRELIMINARY PROPOSAL

Qty	Part No.	Item Description
1	MR_STD_RIG_INST	**MR Standard Rigging and Installation** MR Standard Rigging and Installation This quotation includes standard rigging and installation of your new MAGNETOM system Standard rigging into a room on ground floor level of the building during standard working hours (Mon. - Fri./ 8 a.m. to 5 p.m.) It remains the responsibility of the Customer to prepare the room in accordance with the SIEMENS planning documents Any rigging requiring a crane over 80 tons and/or special site requirements (e.g. removal of existing systems, etc.) is an incremental cost and the responsibility of the Customer. All other "out of scope" charges (not covered by the standard rigging and installation) will be identified during the site assessment and remain the responsibility of the Customer.
1	MR_BTL_INST ALL	**MR Standard Rigging & Install**
1	MR_BUDG_ADDL_RIG	**Budgetary Add'l/Out of Scope Rigging $15,000**
1	MR_PREINST_DOCK	**T+D Preinstall kit for dockable table**
1	MR_CRYO	**Standard Cryogens**
1	MR_PM	**MR Project Management** A Siemens Project Manager (PM) will be the single point of contact for the implementation of your Siemen's equipment. The assigned PM will work with the customer's facilities management, architect or building contractor to assist you in ensuring that your site is ready for installation. Your PM will provide initial and final drawings and will coordinate the scheduling of the equipment, installation, and rigging, as well as the initiation of on-site clinical education.
1	MR_INITIAL_32	**Initial onsite training 32 hrs** MR_INITIAL_32 Up to (32) hours of on-site clinical education training, scheduled consecutively (Monday - Friday) during standard business hours for a maximum of (4) imaging professionals. Training will cover agenda items on the ASRT approved checklist. Uptime Clinical Education phone support is provided during the warranty period for specified posted hours. This educational offering must be completed (12) months from install end date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
1	MR_FOLLOWUP_32	**Follow-up training 32 hrs** Up to (32) hours of follow-up on-site clinical education training, scheduled consecutively (Monday - Friday) during standard business hours for a maximum of (4) imaging professionals. Uptime Clinical Education phone support is provided during the warranty period for specified posted hours. This educational offering must be completed (12) months from install end date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
1	MR_INT_DOT_BCLS	**MR Dot Training Class** Tuition for (1) imaging professional to attend Classroom Course at Siemens Training Center. The objectives of this class are to introduce the user interface of the common syngo platform, including Dot, and instructions on building protocols, demonstration of software functions, and hands-on sessions. This class includes lunch, economy airfare, and lodging for (1) imaging professional. All arrangements must be arranged through Siemens designated travel agency. This educational offering must be completed (12) months from install end date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
1	MR_A_INT_DOT_BCLS	**MR Dot Training Class** Tuition for (1) imaging professional to attend Classroom Course at Siemens Training Center. The objectives of this class are to introduce the user interface of the common syngo platform, including Dot, and instructions on building protocols, demonstration of software functions, and hands-on sessions. This class includes lunch, economy airfare, and lodging for (1) imaging professional. All arrangements must be arranged through Siemens designated travel agency. This educational offering must be completed (12) months from install end date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
1	MR_ADD_32	**Additional onsite training 32 hours** Up to (32) hours of on-site clinical education training, scheduled consecutively (Monday - Friday) during standard business hours for a maximum of (4) imaging professionals. Training will cover agenda items on the ASRT approved checklist if applicable.This educational offering must be completed (12) months from install end date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.

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Qty	Part No.	Item Description
1	MR_BIOMED_TRN	**XX2SYNGO - Syngo with Multimodality Workstation**
1	MR_BIOMED_TRN	**MR1MRESSEN - Service Essentials for MR - (10 Days)**
1	MR_BIOMED_TRN	**MR2AVANTO - MAGNETOM AVANTO and Espree System - (15 days)**
1	MR_BIOMED_TRN	**MR5AERASKY - MAGNETOM Aera/Skyra Upgrade Course - (10 days)**
1	4MR5142869	**Armrest #MR**
1	M3SSMREPICBC	**Spectris Solaris EP Injector iCBC** Includes Spectris Solaris EP injector and Integrated Continuous Battery Charger (ICBC). - Optimized color touch screen with few keystrokes. - Six user-programmable phases for added flexibility. - Independent Keep Vein Open (KVO) allows more time to focus on patient. - Large 115 mL saline syringe allows for longer KVO and multiple flushes. - Design of low pressure tubing eliminates dead space in the "T" connection that can waste contrast. - The clear barrel design with molded FluidDots help detect the presence of air in a syringe. - Pressure Limit Setting control software enables user to select from one to six preset maximum pressure limits, ranging from 100-300 psi, and to view current pressure during injection next to the pre-selected maximum value on the Solaris display. Installation, applications and one year warranty provided by Medrad. Not for mobile use, refer to Siemens part number M3SSMR300EPM for the Solaris injector used in a mobile environment. This product has been tested and verified for compatibility with the following Siemens' products: MAGNETOM Trio, Espree, Essenza, Verio, Avanto, Symphony, Aera, Skyra and Biograph mMR. Compatibility with other products cannot be guaranteed and use with any other products may void service contracts and/or system warranties.
1	CHILINST_AVT	**Chiller Start-up and Warranty for TIM**
1	KKTECOMR_60	**KKT ECOCHILLER 133L** The KKT ECO 133 -L chiller is a dedicated 20°C cooling system for MAGNETOM Aera and MAGNETOM Skyra which automatically adapts to the different cooling requirements (e.g. system in operation, standby, ...) to reduce the energy consumption for cooling. The cooling system must be used in combination with the IFP (Interface Panel), if there is no on-site chilled water supply at all. The IFP is included in the scope of supply.
1	PW9390160UPSBP	**9390 160kVA UPS** Includes: PW9390 160kVA Electronics Cabinet, (1) Battery Cabinet with hold over time of 8 minutes @ .9 pf, UPS includes: Single Feed Option, Hi-Res Delta Kit, and 8" Side Car housing 3-Circuit Breaker, 480V, 35kAIC Integrated Maintenace Bypass. Start-Up (5x8) and One (1) Year On-Site Parts and Labor coverage (7x24), Plus One (1) Year of remote monitoring. Installation including rigging, electrical, and any HVAC required is not included and is the responsibility of the customer or its contractor.

System Total: $2,289,114

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PRELIMINARY PROPOSAL

OPTIONS on Quote Nr: **1-559QUR Rev. 3**

OPTIONS for MAGNETOM Skyra

All items listed below are OPTIONs and will be included on this system ONLY if initialed:

Qty	Part No.	Item Description	Extended Price
1	14418480	**TimCT Onco Dot Engine #T+D** syngo TimCT Onco Dot Engine employs the TimCT Continuous Table move technology for large Field of View applications with smooth workflow and superb image quality. syngo TimCT Oncology is built on the Tim technology as well as on a highly advanced patient table with high positioning accuracy and an RF shielded table drive. Simultaneous coverage of the a large Field of View using local coils with a high signal to noise ratio enables excellent image quality and extremely fast imaging with iPAT. TimCT Onco Dot Engine makes the easy workflow of syngo TimCT even easier by guidance throughout the exam and by providing the coil position and automatic coil selection (AutoCoilSelect).	+ $89,700
1	14401503	**Diffusion Tensor Imaging #Tim**	+ $17,250
1	14401504	**DTI Evaluation #Tim** DTI Evaluation provides advanced post-processing and visualization of Diffusion Tensor Imaging (DTI) data. DTI Evaluation includes the possibility to calculate tensor data from a DTI dataset retrospectively and enables calculation of different diffusion parameter maps. Furthermore it facilitates joint ROI-based evaluation of parameter images and anatomical images, as well as color-coded display and fused 3D visualization in the anatomical context.	+ $17,250
1	07820116	**Single Voxel Spectroscopy #Tim** Integrated software package including sequences and protocols for proton spectroscopy to examine metabolic changes in the brain (e.g. in tumors and degenerative diseases).	+ $8,970
1	14413615	**2D Chemical Shift Imaging #Tim** Sequences and protocols for proton 2D Chemical Shift Imaging (2D CSI).	+ $7,590
1	14413621	**3D Chemical Shift Imaging #Tim** Sequences and protocols for proton 3D Chemical Shift Imaging (3D CSI).	+ $6,210
1	07365385	**Spectroscopy Evaluat.syngo**	+ $11,730
1	14416943	**Neuro fMRI Package #T+D** The Neuro fMRI Package is a bundle of: - Inline BOLD Imaging - 3D PACE syngo - BOLD 3D Evaluation syngo - fMRI Trigger Converter The bundle comprehends all acquisition and post processing tools for comprehensive BOLD fMRI exams.	+ $39,882
1	14416923	**Abdomen Dot Engine #T+D** The Abdomen Dot Engine: Personalized Exam Strategies - Guidance - Automatic sequence scaling - Auto Navigator - Auto-FoV - Timeline setup and monitoring - Automatic Voice Commands - Auto Bolus Detection - Inline radial range calculation for MRCP - Inline Subtraction - Inline Registration	+ $41,400

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Qty	Part No.	Item Description	Extended Price
1	PW9390160PCBP	**9390 160kVA Power Conditioner** Includes: PW9390 160kVA Electronics Cabinet configured as Power Conditioner @ .9 pf, Power Conditioner includes: Single Feed Option, Hi-Res Delta Kit, and 8" Side Car housing 3-Circuit Breaker, 480V, 35kAIC Integrated Maintenace Bypass. Start-Up (5x8) and One (1) Year On-Site Parts and Labor coverage (7x24), Plus One (1) Year of remote monitoring. Installation including rigging, electrical, and any HVAC required is not included and is the responsibility of the customer or its contractor.	+ $41,400

FINANCING: The equipment listed above may be financed through Siemens. Ask us about our full range of financial products that can be tailored to meet your business and cash flow requirements. For further information, please contact your local Sales Representative.

Siemens Healthcare is pleased to submit this Preliminary Pricing Proposal. A Preliminary Pricing Proposal is provided for planning purposes only; it is not contractually binding. To receive a contractually binding proposal for the Products listed above, inclusive of Terms, Conditions, and Warranty coverage, please contact your Siemens Healthcare Sales Representative.

Siemens Healthcare

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Consolidated Interim Financial Statements

May 31, 2014

This financial report is confidential and proprietary information. This document is not a public record until finalized and released by the chief financial officer. The embargo date for the information contained herein is June 26, 2014 at 5P.M. EST. No part of the information contained herein may be released or discussed publicly until this date.

ERLANGER HEALTH SYSTEM
Unaudited Consolidated Balance Sheets as of: May 31, 2014

ASSETS	2014	2013
UNRESTRICTED FUND		
CURRENT:		
Cash and temporary investments	$ 45,264,146	$ 29,637,443
Funds held by trustee - current portion	24,811	28,669
Patient accounts receivable	312,315,359	275,882,672
Less allowances for patient A/R	(227,388,003)	(199,240,929)
Net patient accounts receivable	84,927,356	76,641,743
Other receivables	31,695,484	33,801,897
Due from third party payors	8,635,480	4,812,067
Inventories	13,494,520	12,957,913
Prepaid expenses	8,008,914	6,819,235
Total current assets	192,050,711	164,698,968
PROPERTY, PLANT, AND EQUIPMENT		
Net property, plant and equipment	153,925,617	164,799,817
LONG-TERM INVESTMENTS	299,526	388,750
OTHER ASSETS:		
Assets whose use is limited	131,944,415	129,862,927
Deferred debt issue cost	5,271,566	5,885,831
Other assets	1,912,082	2,080,565
Total other assets	139,128,063	137,829,323
TOTAL	**$ 485,403,918**	**$ 467,716,857**

LIABILITIES	2014	2013
UNRESTRICTED FUND		
CURRENT:		
Current maturities of long term debt	$ 10,821,713	$ 8,481,075
Accounts payable	41,993,980	43,913,082
Accrued salaries & related liabilities	17,811,887	17,619,755
Due to third party payors	93,625	2,060,740
Construction fund payable	171,727	206,175
Accrued Interest payable	1,175,071	1,308,205
Total current liabilities	72,068,002	73,589,033
POST RETIREMENT BENEFITS (GASB 45 & FAS 112)	28,140,752	15,172,411
RESERVE FOR OTHER LIABILITIES	27,239,588	25,571,930
LONG - TERM DEBT	159,027,238	169,534,471
FUND BALANCE:		
Unrestricted	183,745,515	166,061,296
Invested in capital assets, net of related debt	10,088,278	13,404,495
Restricted	5,094,546	4,383,221
	198,928,338	183,849,012
TOTAL	**$ 485,403,918**	**$ 467,716,857**

Erlanger Health System

Unaudited Consolidated Statement of Operations

For the periods ended May 31, 2014 and 2013

	Current Month			Year to Date		
	Actual	Budget	Prior Year	Actual	Budget	Prior Year
Net patient service revenue	$ 51,121,996	$ 49,530,881	$ 46,022,661	$ 531,120,254	$ 515,288,565	$ 492,072,380
Other revenue(expense)	2,332,240	3,015,575	3,209,894	33,386,450	32,401,785	31,528,180
Net operating revenue	53,454,236	52,546,455	49,232,555	564,506,704	547,690,350	523,600,561
Expenses						
Salaries and employee benefits	28,095,882	27,783,199	27,288,480	292,990,706	302,336,570	289,767,795
Supplies	6,935,202	6,715,250	5,820,282	74,623,600	69,772,828	71,133,524
Purchased services	10,224,525	9,442,841	10,468,173	107,281,309	102,736,447	106,742,050
Utilities	644,225	818,777	774,224	8,889,067	8,850,504	8,768,405
Drugs	3,629,447	3,216,175	2,810,832	35,102,426	34,253,405	30,741,499
Depreciation	1,998,243	2,498,080	2,177,420	25,006,228	26,999,696	24,210,923
Insurance & taxes	270,714	273,170	91,095	3,122,740	3,021,742	2,106,037
Total operating expense	51,798,237	50,747,492	49,430,506	547,016,077	547,971,192	533,470,233
Excess rev. over/(under) exp. from operations	1,655,999	1,798,964	(197,950)	17,490,627	(280,842)	(9,869,672)
NONOPERATING INCOME:						
Gain (Losses) on disposal of assets	(20,401)	(17,816)	3,660	(206,124)	(192,692)	(233,019)
Interest Income/Gains (Losses) on Investments	373,353	211,769	(593,261)	2,128,375	2,151,068	579,014
Interest expense	(733,384)	(749,125)	(763,003)	(8,171,145)	(8,095,538)	(8,398,694)
Mark to market on swaps	(120,977)	-	618,348	1,046,674	-	2,138,201
Provisions for income tax	1,250	(22,490)	21,810	(5,020)	104,460	(91,710)
Excess rev. over/(under) expenses	$ 1,155,840	$ 1,221,301	$ (910,398)	$ 12,283,386	$ (6,313,544)	$ (15,875,880)
Operating Margin	3.10%	3.42%	-0.40%	3.10%	-0.05%	-1.88%
Total Margin	2.39%	2.32%	-3.11%	1.99%	-1.15%	-3.44%

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System and Aggregate Discretely Presented Component Units)

Audited Combined Financial Statements

Years Ended June 30, 2013 and 2012

PYA
Certified Public Accountants

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Audited Combined Financial Statements

Years Ended June 30, 2013 and 2012

PYA
Certified Public Accountants

PERSHING YOAKLEY & ASSOCIATES, P.C.
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INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of
Chattanooga-Hamilton County Hospital Authority
(d/b/a Erlanger Health System):

Report on the Financial Statements

We have audited the accompanying combined financial statements of the business-type activities of Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System (the Primary Health System) and its aggregate discretely presented component units, as of and for the years ended June 30, 2013 and 2012, and the related notes to the financial statements, which collectively comprise the Primary Health System's basic combined financial statements as listed in the table of contents.

Management's Responsibility for the Combined Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Primary Health System's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness

of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and the aggregate discretely presented component units of the Primary Health System as of June 30, 2013 and 2012, and the respective changes in financial position and, where applicable, cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matters

As discussed in Note A to the combined financial statements, during 2013 the Primary Health System adopted the provisions of Governmental Accounting Standards Board Statement No. 61, *The Financial Reporting Entity: Omnibus - an Amendment of GASB Statements No. 14 and No.34*. Our opinion is not modified with respect to this matter.

Other Matters

Required Supplementary Information: Accounting principles generally accepted in the United States of America require that the management's discussion and analysis (shown on pages 3 through 11) be presented to supplement the combined financial statements. Such information, although not a part of the combined financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic combined financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the combined financial statements, and other knowledge we obtained during our audit of the combined financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Pershing Yoakley & Associates PC

Knoxville, Tennessee
September 17, 2013

Management's Discussion and Analysis

MANAGEMENT'S DISCUSSION AND ANALYSIS

The discussion and analysis of Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System's financial performance provides an overview of the Primary Health System's financial activities for the fiscal years ended June 30, 2013, 2012 and 2011.

Erlanger Health System (the Primary Health System) is the largest healthcare provider in Southeast Tennessee. The Primary Health System maintains a number of very specialized clinical services such as Level I trauma, Level III neonatal, kidney transplantation, a Regional Cancer Unit, a full service children's hospital, and open heart surgery, all of which are primarily serviced by four "Life Force" helicopters and supported by subspecialty physicians (residents, faculty and private attending physicians) located on its campuses.

OVERVIEW OF THE COMBINED FINANCIAL STATEMENTS

The combined financial statements consist of two parts: Management's Discussion and Analysis and the combined financial statements. The combined financial statements also include notes that explain in more detail some of the information in the combined financial statements.

The combined financial statements of the Primary Health System offer short-term and long-term financial information about its activities. The combined statements of net position include all of the Primary Health System's assets and liabilities and provide information about the nature and amounts of investments in resources (assets) and the obligations to the Primary Health System's creditors (liabilities). The assets and liabilities are presented in a classified format, which distinguishes between current and long-term assets and liabilities. It also provides the basis for computing rate of return, evaluating the capital structure of the Primary Health System and assessing the liquidity and financial flexibility of the Primary Health System.

All of the fiscal year's revenues and expenses are accounted for in the combined statements of revenue, expenses, and changes in net position. These statements measure the success of the Primary Health System's operations and can be used to determine whether the Primary Health System has successfully recovered all of its costs through the services provided, as well as its profitability and credit worthiness.

The final required financial statements is the combined statements of cash flows. The primary purpose of these statements is to provide information about the Primary Health System's cash receipts, cash payments and net changes in cash resulting from operating, investing, non-capital financing and financing activities. The statements also provide answers to such questions as where did cash come from, what was cash used for, and what was the change in the cash balance during the reporting period.

OVERVIEW OF THE COMBINED FINANCIAL STATEMENTS - Continued

The analyses of the combined financial statements of the Primary Health System begins on the next page. One of the most important questions asked about the Primary Health System's finances is "Is the financial condition of the Primary Health System as a whole better or worse as a result of the fiscal year's activities?" The combined statements of net position and the combined statements of revenue, expenses and changes in net position report information about the Primary Health System's activities in a way that will help answer this question. These two statements report the net position of the Primary Health System and changes in in the net position. One can think of the Primary Health System's net position – the difference between assets and liabilities – as one way to measure financial health or financial position. Over time, increases or decreases in the Primary Health System's net position is one indicator of whether its financial health is improving or deteriorating. However, one will need to consider other non-financial factors such as changes in economic conditions, regulations and new or changed government legislation.

REPORTING ENTITY

The Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System (the Primary Health System) was created by a private act passed by the General Assembly of the State of Tennessee on March 11, 1976, and adopted by a majority of the qualified voters of Hamilton County, Tennessee on August 5, 1976. The Primary Health System is considered the primary governmental unit for financial reporting purposes. As required by generally accepted accounting principles, these financial statements present the Primary Health System and its component units. The component units discussed below are included in the Primary Health System's reporting entity because of the significance of their operational or financial relationships with the Primary Health System.

ContinuCare HealthServices, Inc., Plaza Surgery, G.P., Cyberknife of Chattanooga, LLC (Cyberknife), UT-Erlanger Medical Group, Inc. (the Medical Group) and Erlanger Health Plan Trust are legally separate organizations for which the Primary Health System is either financially accountable or owns a majority interest. Accordingly, these organizations represent component units of the Primary Health System. The financial statements of Erlanger Health Plan Trust are blended with the financial statements of the Primary Health System, as the Board of Erlanger Health Plan Trust is substantially the same as that of the Primary Health System and the Primary Health System has operational responsibility.

During 2012, the Primary Health System acquired 100% ownership in Plaza Surgery, G.P. As a result, Plaza Surgery, G.P.'s operations are no longer distinct from the Primary Health System.

REPORTING ENTITY - Continued

During fiscal year 2011, Cyberknife was capitalized by contributions from the Primary Health System and certain other minority partners. Cyberknife provides radiation therapy services, specifically robotic stereotactic radiosurgical services through the use of a Cyberknife stereotactic radiosurgery system on the Primary Health System campus. At June 30, 2013, 2012 and 2011, the Primary Health System owned 51% of Cyberknife's outstanding membership units. The Medical Group was formed on June 30, 2011 and will provide professional healthcare and related services to the public through its employed and contracted licensed physicians and other supporting healthcare providers. The Medical Group has no members; however, the Primary Health System may access the Medical Group's services. The Primary Health System is not entitled to any potential earnings of the Medical Group except for compensation for services rendered to the Medical Group on its behalf. The Medical Group is currently not active.

KEY FINANCIAL INDICATORS

The following key financial indicators are for Erlanger Health System as a whole. They are inclusive of the Primary Health System, ContinuCare HealthServices, Inc., and the 51% controlling share of Cyberknife of Chattanooga, LLC.

- Excess expenses over revenues from operations for Erlanger Health System for the fiscal year 2013 is $7.9 million compared to excess revenues over expenses of $9.5 million for the fiscal year 2012 and excess revenues over expenses of $5.4 million for the fiscal year 2011.
- Total cash and investment reserves at June 30, 2013 are $38 million (excluding $99 million of Board restricted and $31 million of funds held by Trustees or restricted by donors or others).
- Net days in accounts receivable for Erlanger Health System (utilizing a three month rolling average of net revenue) is 50 days at June 30, 2013 compared to 53 days at June 30, 2012 and 57 days at June 30, 2011.
- For fiscal year 2013, Erlanger Health System recognized $10.6 million in essential access payments from the State of Tennessee compare to $11.4 million in fiscal year 2012 and $7.4 million in fiscal year 2011.
- For fiscal year 2013, Erlanger Health System recognized $8.5 million in disproportionate share payments from the State of Tennessee compared to $9.2 million in fiscal year 2012 and $2.9 million in fiscal year 2011.
- For fiscal year 2012, Erlanger Health System recognized $1.1 million in trauma fund payments from the State of Tennessee compared to $1.0 million in fiscal year 2012 and $1.1 million in fiscal year 2011.
- For fiscal year 2012, Erlanger Health System recognized $3.2 million in a Medicare rural floor budget neutrality settlement payment.

KEY FINANCIAL INDICATORS - Continued

- For fiscal year 2011, Erlanger Health System recognized $2.9 million in a one-time supplemental distribution from the Tennessee Hospital Assessment Fund.

The required bond covenants ratios for fiscal year 2013 compared to bond requirements are as follows:

		Master	*Bond Insurer Requirements*		
	June 30, 2013	*Trust Indenture*	*98 Series*	*00 Series*	*04 Series*
Debt service coverage ratio	1.11	1.10	1.10	1.35	1.35
Cushion ratio	6.71	N/A	1.50	N/A	N/A
Current ratio	2.12	N/A	1.50	1.50	1.50
Days cash on hand	70 days			65 days	65 days
Indebtedness ratio	51.31%				65%

The trust indentures and related documents underlying the bonds contain certain covenants and restrictions. For fiscal years 2013 and 2012, the Primary Health System failed to satisfy the debt service coverage ratio required by one of the bond insurers. As a result of the non-compliance, the Primary Health System will be required to engage a management consultant or obtain a waiver from the bond insurer.

NET POSITION

Erlanger Health System's net position for the combined Primary Health System and Aggregate Discretely Presented Component Units decreased by approximately $14 million in the fiscal year 2013. Our analysis focuses on the net position (Table 1) and changes in net position (Table 2) of the Primary Health System's operating activities. Discussion focuses on the Primary Health System and its blended component units.

Net position for the Primary Health System decreased from $200 million as of June 30, 2012 to $186 million as of June 30, 2013. The current ratio (current assets divided by current liabilities) decreased from 2.33 in 2012 to 2.12 in 2013 for the Primary Health System.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Management's Discussion and Analysis - Continued

Years Ended June 30, 2013 and 2012

NET POSITION - Continued

Table 1- Net Position (in Millions)

	June 30, 2013		*June 30, 2012*		*6/30/2011 (before GASB 61 adoption)*	
	Primary Health System	*Aggregate Discretely Presented Component Units*	*Primary Health System*	*Aggregate Discretely Presented Component Units*	*Primary Health System*	*Aggregate Discretely Presented Component Units*
Current and other assets	$ 313	$ 12	$ 328	$ 12	$ 335	$ 14
Capital assets	161	10	158	10	163	7
Total assets	$ 474	$ 22	$ 486	$ 22	$ 498	$ 21
Long-term debt outstanding	$ 169	$ 4	$ 177	$ 4	$ 179	$ 4
Other liabilities	119	4	109	4	115	3
Total liabilities	$ 288	$ 8	$ 286	$ 8	$ 294	$ 7
Net position						
Capital assets, net of debt	$ 10	$ 6	$ -	$ 5	$ 5	$ 2
Restricted, expendable	2	-	2	-	3	-
Unrestricted	174	8	198	9	196	12
Total net position	$ 186	$ 14	$ 200	$ 14	$ 204	$ 14

Days in cash decreased from 81 days as of June 30, 2012 to 73 days as of June 30, 2013 for the Primary Health System resulting from decreased operating margins combined with an $8 million increase in receivable for funds drawn on a line of credit extended to Hutcheson Medical Center, Inc. in fiscal year 2013. Days in cash decreased from 105 days as of June 30, 2011 to 81 days as of June 30, 2012 for the Primary Health System due to decreased operating margins combined with a $12.5 million receivable for funds drawn on a line of credit extended to Hutcheson Medical Center, Inc. in fiscal year 2012.

Days in net accounts receivable decreased from 55 days as of June 30, 2012 to 51 days as of June 30, 2013. Days in net accounts receivable decreased from 57 days as of June 30, 2011 to 55 days as of June 30, 2012.

Capital assets for the Primary Health System were $161 million. Additions for fiscal year 2013 totaled $30 million while $4 million of assets were retired. Depreciation expense was $27 million for the Primary Health System. Retirement of assets reduced accumulated depreciation by $4 million in fiscal year 2013. Construction in progress was $9 million as of June 30, 2013.

NET POSITION - Continued

Included in construction in progress at June 30, 2013 are surgical suite expansion projects totaling $3.2 million. Additions for the fiscal year 2012 amounted to $31 million while $59 million of assets were retired. The retirements included the sale and minority tenant leaseback of certain professional office buildings. A gain on the sale of approximately $6.6 million was realized of which $4.9 million was deferred. Depreciation expense was $26 million for the Primary Health System in fiscal year 2012. Retirement of assets reduced accumulated depreciation by $52 million in fiscal year 2012. Construction in progress was $11 million as of June 30, 2011 and $7 million as of June 30, 2012. Included in construction in progress at June 30, 2012 is the Erlanger East expansion of $3.5 million.

	Primary Health System		
	2013	*2012*	*2011*
Land and improvements	$ 26	$ 25	$ 27
Buildings	231	224	243
Equipment	367	351	357
Total	624	600	627
Less accumulated depreciation	(472)	(449)	(475)
Construction in progress	9	7	11
Net property, plant and equipment	$ 161	$ 158	$ 163

Long-term debt outstanding amounted to $169 million as of June 30, 2013 compared to $177 million as of June 30, 2012. The decrease in long-term debt reflects normal scheduled principal payments. Long-term debt outstanding amounted to $177 million as of June 30, 2012 compared to $179 million as of June 30, 2011. The decrease in long-term debt reflects normal scheduled principal payments net of an increase in debt associated with the sale and minority tenant leaseback of the Erlanger East POB.

Other liabilities for the Primary Health System were $119 million as of June 30, 2013, $108 million at June 30, 2012, compared to $115 million as of June 30, 2011.

CHANGES IN NET POSITION

The focus for Erlanger Health System's management team during fiscal year 2013 and 2012 was to increase the Primary Health System's volumes in a number of key product lines in a downturned economy, improve relationships with stakeholders, and improve operating efficiencies.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Management's Discussion and Analysis - Continued

Years Ended June 30, 2013 and 2012

CHANGES IN NET POSITION - Continued

Table 2- Changes in Net Position (in Millions)

	June 30, 2013		*June 30, 2012*		*June 30, 2011*	
	Primary Health System	*Aggregate Discretely Presented Component Units*	*Primary Health System*	*Aggregate Discretely Presented Component Units*	*Primary Health System*	*Aggregate Discretely Presented Component Units*
Net patient revenue	$ 526	$ 12	$ 514	$ 12	$ 513	$ 11
Other revenue	19	16	22	16	20	15
Total revenue	545	28	536	28	533	26
Expenses:						
Salaries	298	13	300	13	292	12
Supplies and expenses	111	10	111	10	112	13
Purchased services	114	3	104	3	94	1
Insurance and taxes	2	1	5	1	4	-
Depreciation and amortization	27	1	26	1	26	-
Total expenses	552	28	546	28	528	26
Operating income revenues in excess of (less than) expenses	(7)	-	(10)	-	5	-
Nonoperating gains	-	-	4	-	2	-
Interest expense and other	(7)	-	(11)	-	(8)	-
Operating/capital contributions	-	-	-	-	1	-
Change in net position	$ (14)	$ -	$ (17)	$ -	$ -	$ -

Net patient service revenue for the Primary Health System increased from $514 million in fiscal year 2012 to $526 million in fiscal year 2013. Admissions for fiscal year 2013 were comparable to fiscal year 2012, however, case mix increased over the prior year by 1.6%. The Erlanger East emergency room opened in March 2013 generating 6,100 additional emergency room visits. Net patient service revenue for the Primary Health System increased from $513 million in fiscal year 2011 to $514 million in fiscal year 2012. Although total admissions were up 3.9% over fiscal year 2011, inpatient surgical patients decreased 4.9% over prior year which resulted in a higher medicine mix of patients. Neonatal intensive care unit patient days decreased by 8.7% compared to prior year.

Salaries for the Primary Health System decreased from $300 million in fiscal year 2012 to $298 million in fiscal year 2013. Paid FTE's per adjusted occupied bed decreased from 5.60 in fiscal year 2012 to 5.40 in fiscal year 2013. Salaries for the Primary Health System increased from $292 million in fiscal year 2011 to $300 million in fiscal year 2012 due to continued growth in strategically critical new physician practices, increase in employee benefits, and approximately $2.6 million in severance payments resulting from a reduction in workforce.

CHANGES IN NET POSITION - Continued

Supplies and other expenses were $111 million for fiscal years 2013 and 2012. Supplies and drugs per adjusted admission for the Primary Health System decreased from $1,675 in fiscal year 2012 to $1,587 in fiscal year 2013. Supplies and expenses decreased from $112 million in fiscal year 2011 to $111 million in fiscal year 2012.

Purchased Services increased from $104 million in fiscal year 2012 to $114 million in fiscal year 2013 due to contracted service expenditures assumed with the purchase of Plaza Surgery's minority interest, fees associated with the CEO search, fees associated with the third party operational assessment and implementation, and an increase in rent expense resulting from the sale of the Erlanger East POB. Purchased services increased from $94 million in fiscal year 2011 to $104 million in fiscal year 2012 due to the implementation of Cyberknife services, service excellence initiatives, outsourced security services and billing service fees associated with increased employed physicians' revenue.

Insurance and taxes decreased by $2.5 million from fiscal year 2012 to fiscal year 2013 due to insurance payment received for prior year liability, decreased malpractice liability, and decreased expenses associated with the purchase of Plaza Surgery, G.P. Insurance and taxes increased from $4 million in fiscal year 2011 to $5 million in fiscal year 2012 due to increased malpractice liability.

Depreciation and amortization expense increased from $26 million in fiscal year 2012 to $27 million in fiscal year 2013 due, in part, to the addition of the Erlanger East emergency room. Depreciation and amortization expense was $26 million in fiscal years 2011 and 2012.

Interest expense, including gain (or loss) on mark-to-market of interest rate swaps, decreased from $11 million in fiscal year 2012 to $7 million in fiscal year 2013. The market value of the liability for the mark-to-market of interest rate swaps decreased by $2.3 million in fiscal year 2013 compared to an increase of $1.1 million in fiscal year 2012. Interest expense, including gain (or loss) on mark-to-market of interest rate swaps, increased from $8 million in fiscal year 2011 to $11 million in fiscal year 2012. The market value of the liability for the mark-to-market of interest rate swaps increased by $1.1 million in fiscal year 2012 compared to a decrease of $1.6 million in fiscal year 2011.

OUTLOOK

The State of Tennessee continues to review the TennCare program (the State's Medicaid program). For fiscal years 2011 and 2012, the State passed a Hospital Coverage Fee to offset shortfalls in the State's budget for TennCare. The fee is remained intact for the third consecutive year and TennCare rates were stable in fiscal year 2013. There could be possible TennCare rate

OUTLOOK - Continued

changes in fiscal year 2014 as a result of rate variation initiatives. Out-of-state Medicaid and TennCare changes would affect the Primary Health System's bottom line with TennCare and Medicaid patients representing approximately 24% of the payer mix. Self Pay patients represent approximately 10% of the charge utilization Healthcare reform and future changes in Medicare regulations could also have an adverse effect on the Primary Health System's future operations since Medicare represents approximately 30% of the payer mix.

The Primary Health System is currently pursuing participation in the Public Hospital Supplemental Payment Pool which could result in additional funding.

The Primary Health System recognized Essential Access and Disproportionate Share payments totaling $19.1 million from the State of Tennessee for fiscal year 2013, a decrease of $1.5 million from fiscal year 2012. The Primary Health System recognized Essential Access and Disproportionate Share payments from the State of Tennessee fiscal year 2012 which increased by $10 million over fiscal year 2011. Additionally, the Primary Health System recognized trauma funding of $1.1 million in fiscal year 2013 compared to $1 million in fiscal year 2012 and $1.1 million in fiscal year 2011. Payments from the State of Tennessee for the fiscal year 2014 are expected to be consistent with the fiscal year 2013 except for disproportionate share. The funding of disproportionate share for fiscal year 2014 has not been approved by the Federal government. However, it is likely that the Federal government will approve this extension. Due to the 1966 Hamilton County Sales Tax Agreement expiring in May 2011, the Hamilton County appropriations to the Primary Health System have been reduced from $3 million to $1.5 million for fiscal years 2013 and 2012. An increase for the fiscal year 2014 is unlikely.

Several initiatives are under way to bring the Primary Health System to a profitable position for the upcoming fiscal year. Operating improvements are being implemented to reduce expenses and grow surgical volumes. Increased surgery volumes are essential to the financial health of the Primary Health System.

Audited Combined Financial Statements

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Net Position

	June 30, 2013	
	Primary Health System	*Aggregate Discretely Presented Component Units*
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	$ 17,250,905	$ 930,587
Temporary investments	13,797,542	2,938,131
Assets limited as to use available for current liabilities	28,275	-
Patient accounts receivable, net	73,561,669	2,408,177
Estimated amounts due from third party payors	3,116,389	-
Due from other governments	528,032	377,239
Inventories	11,861,728	1,161,097
Receivable from Hutcheson Medical Center	20,550,000	-
Other current assets	20,129,320	1,917,719
TOTAL CURRENT ASSETS	160,823,860	9,732,950
NET PROPERTY, PLANT AND EQUIPMENT	160,973,575	9,643,816
LONG-TERM INVESTMENTS, for working capital	1,790,946	1,599,946
ASSETS LIMITED AS TO USE	130,231,028	-
OTHER ASSETS:		
Deferred financing costs	5,833,775	-
Equity in discretely presented component units and other	13,639,860	-
Other assets	437,820	858,972
TOTAL OTHER ASSETS	19,911,455	858,972
TOTAL ASSETS	$ 473,730,864	$ 21,835,684
LIABILITIES AND NET POSITION		
CURRENT LIABILITIES:		
Accounts payable and accrued expenses	$ 46,945,723	$ 1,425,315
Accrued salaries and related liabilities	19,131,496	910,318
Estimated amounts due to third party payors	-	93,625
Due to other governments	377,239	528,032
Current portion of long-term debt and capital lease obligations	8,058,625	556,698
Other current liabilities	2,194,117	838,223
TOTAL CURRENT LIABILITIES	76,707,200	4,352,211
LONG-TERM DEBT AND CAPITAL LEASE OBLIGATIONS	169,370,173	3,445,959
OTHER LONG-TERM LIABILITIES	41,790,984	-
NET POSITION:		
Unrestricted	173,517,742	8,321,046
Net investment in capital assets	10,125,742	5,716,468
Restricted expendable	2,219,023	-
TOTAL NET POSITION	185,862,507	14,037,514
TOTAL LIABILITIES AND NET POSITION	$ 473,730,864	$ 21,835,684

	June 30, 2012	
	Primary Health System	*Aggregate Discretely Presented Component Units*
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	$ 27,820,469	$ 35,714
Temporary investments	14,510,657	3,210,896
Assets limited as to use available for current liabilities	33,250	-
Patient accounts receivable, net	76,641,438	2,325,057
Due from other governments	905,829	501,472
Inventories	11,566,908	1,155,064
Other current assets	24,383,555	1,528,889
TOTAL CURRENT ASSETS	155,862,106	8,757,092
NET PROPERTY, PLANT AND EQUIPMENT	157,718,163	9,884,006
LONG-TERM INVESTMENTS, for working capital	262,396	2,608,721
ASSETS LIMITED AS TO USE	138,419,178	-
OTHER ASSETS:		
Deferred financing costs	6,458,443	-
Receivable from Hutcheson Medical Center	12,500,000	-
Equity in discretely presented component units and other	13,901,747	175,000
Other assets	461,820	956,272
TOTAL OTHER ASSETS	33,322,010	1,131,272
TOTAL ASSETS	$ 485,583,853	$ 22,381,091
LIABILITIES AND NET POSITION		
CURRENT LIABILITIES:		
Accounts payable and accrued expenses	$ 36,758,702	$ 630,903
Accrued salaries and related liabilities	19,266,509	937,705
Estimated amounts due to third party payors	380,898	93,625
Due to other governments	501,472	905,829
Current portion of long-term debt and capital lease obligations	7,929,701	500,000
Other current liabilities	2,088,573	1,120,629
TOTAL CURRENT LIABILITIES	66,925,855	4,188,691
LONG-TERM DEBT AND CAPITAL LEASE OBLIGATIONS	177,310,823	3,916,667
OTHER LONG-TERM LIABILITIES	41,397,245	-
NET POSITION:		
Unrestricted	197,982,061	8,733,085
Net investment in capital assets	(233,917)	5,542,648
Restricted expendable	2,201,786	-
TOTAL NET POSITION	199,949,930	14,275,733
TOTAL LIABILITIES AND NET POSITION	$ 485,583,853	$ 22,381,091

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Revenue, Expenses and Changes in Net Position

	Year Ended June 30, 2013	
	Primary Health System	*Aggregate Discretely Presented Component Units*
OPERATING REVENUE:		
Charges for services:		
Net patient service revenue	$ 526,139,300	$ 11,345,856
Other revenue	18,969,187	16,241,907
TOTAL OPERATING REVENUE	545,108,487	27,587,763
OPERATING EXPENSES:		
Salaries, wages and benefits	297,831,739	13,607,440
Supplies and other expenses	110,970,317	10,199,559
Purchased services	114,011,044	2,981,048
Insurance and taxes	2,476,434	295,336
Depreciation	26,856,073	1,045,235
TOTAL OPERATING EXPENSES	552,145,607	28,128,618
OPERATING LOSS	(7,037,120)	(540,855)
NONOPERATING REVENUE (EXPENSES):		
Gain on disposal of assets	244,660	590,326
Interest and investment income	24,827	104,642
Net loss from discretely presented component units and other	(261,887)	(175,000)
Interest expense	(9,542,163)	(208,669)
Provision for income taxes	-	(8,663)
Change in mark-to-market of interest rate swaps	2,256,035	-
NET NONOPERATING REVENUE (EXPENSES)	(7,278,528)	302,636
Loss before contributions	(14,315,648)	(238,219)
Operating contributions (distributions)	7,248	-
Capital contributions/other, net	220,977	-
CHANGE IN NET POSITION	(14,087,423)	(238,219)
NET POSITION AT BEGINNING OF YEAR	199,949,930	14,275,733
NET POSITION AT END OF YEAR	$ 185,862,507	$ 14,037,514

	Year Ended June 30, 2012	
	Primary Health System	*Aggregate Discretely Presented Component Units*
OPERATING REVENUE:		
Charges for services:		
Net patient service revenue	$ 514,081,693	$ 11,758,042
Other revenue	22,467,500	16,271,756
TOTAL OPERATING REVENUE	536,549,193	28,029,798
OPERATING EXPENSES:		
Salaries, wages and benefits	300,099,607	13,101,376
Supplies and other expenses	111,165,013	10,454,042
Purchased services	103,908,488	2,788,577
Insurance and taxes	4,921,912	366,516
Depreciation	26,241,609	848,875
TOTAL OPERATING EXPENSES	546,336,629	27,559,386
OPERATING INCOME (LOSS)	(9,787,436)	470,412
NONOPERATING REVENUE (EXPENSES):		
Gain (loss) on disposal of assets	1,815,605	(17,139)
Interest and investment income	2,363,937	127,910
Net gain from discretely presented component units and other	186,011	-
Interest expense	(10,232,817)	(218,057)
Provision for income taxes	-	(160,547)
Change in mark-to-market of interest rate swaps	(1,080,176)	-
NET NONOPERATING EXPENSES	(6,947,440)	(267,833)
Income (loss) before contributions	(16,734,876)	202,579
Operating distributions	(198,111)	-
Capital contributions/other, net	(231,984)	-
CHANGE IN NET POSITION	(17,164,971)	202,579
NET POSITION AT BEGINNING OF YEAR (as previously reported)	204,011,165	14,073,154
CUMULATIVE EFFECT OF CHANGE IN ACCOUNTING PRINCIPLE	13,103,736	-
NET POSITION AT BEGINNING OF YEAR	217,114,901	14,073,154
NET POSITION AT END OF YEAR	$ 199,949,930	$ 14,275,733

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Cash Flows

	Primary Health System Year Ended June 30, 2013	*2012*
CASH FLOWS FROM OPERATING ACTIVITIES:		
Receipts from third-party payors and patients	$ 527,371,215	$ 522,376,450
Payments to vendors and others for supplies, purchased services, and other expenses	(217,039,131)	(222,829,499)
Payments to and on behalf of employees	(297,118,972)	(308,557,666)
Other receipts	23,375,977	17,223,307
NET CASH PROVIDED BY OPERATING ACTIVITIES	36,589,089	8,212,592
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES:		
Contributions (distributions)	7,248	(198,111)
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Acquisition and construction of capital assets, net	(30,339,955)	(20,962,299)
Principal paid on bonds, capital lease obligations and other	(7,900,842)	(7,396,156)
Proceeds from sale of assets	473,130	11,256,695
Interest payments on long-term debt	(8,971,728)	(9,652,060)
Capital contributions/other, net	220,977	(231,984)
NET CASH USED IN CAPITAL AND RELATED FINANCING ACTIVITIES	(46,518,418)	(26,985,804)
CASH FLOWS FROM INVESTING ACTIVITIES:		
Interest, dividends, and net realized gains (losses) on investments	2,468,950	2,168,553
Change in long-term investments for working capital	(815,435)	20,444,766
Advances under note agreeements	(8,050,000)	(12,948,997)
Cash provided by assets limited as to use	5,749,002	1,481,562
NET CASH (USED IN) PROVIDED BY INVESTING ACTIVITIES	(647,483)	11,145,884
DECREASE IN CASH AND CASH EQUIVALENTS	(10,569,564)	(7,825,439)
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR	27,820,469	35,645,908
CASH AND CASH EQUIVALENTS AT END OF YEAR	$ 17,250,905	$ 27,820,469

	Primary Health System Year Ended June 30, 2013	*2012*
RECONCILIATION OF OPERATING LOSS TO NET CASH PROVIDED BY OPERATING ACTIVITIES:		
Operating loss	$ (7,037,120)	$ (9,787,436)
Adjustments to reconcile operating loss to net cash provided by operating activities:		
Depreciation	26,856,073	26,241,609
Amortization of deferred liabilities	(620,506)	(155,750)
Provision for self-insurance	178,439	1,203,978
Non-cash operating revenue recognized on Plaza Surgery acquisition	-	(2,175,057)
Changes in assets and liabilities:		
Patient accounts receivable, net	3,079,769	3,803,194
Estimated amounts due from (due to) third party payors, net	(3,497,287)	8,467,153
Inventories and other assets	6,261,212	(7,061,422)
Accounts payable and accrued expenses	10,187,021	(3,268,775)
Accrued salaries and related liabilities	(135,013)	(8,985,999)
Other current and long-term liabilities	1,316,501	(68,903)
NET CASH PROVIDED BY OPERATING ACTIVITIES	$ 36,589,089	$ 8,212,592

SUPPLEMENTAL INFORMATION:

During the year ended June 30, 2012, the Primary Health System entered into several capital leases with third parties for office space. The capital leases represented liabilities at the inception of the leases of approximately $6,600,000. Additionally, in 2012, as a result of the acquisition of all outstanding units of Plaza Surgery, G.P. (see Note A) deferred receipts were recognized as other operating revenue. Further, in connection with the gain on the sale of property discussed in Note E, proceeds due to Primary Health System of $2,355,000 were withheld and are reflected as other current assets in the combined statements of net position at June 30, 2012. The Primary Health System received the remaining proceeds during the year ended June 30, 2013.

During the year ended June 30, 2013, The Primary Health System received a commitment from a third party to reimburse the Primary Health System for $1,900,000 in renovations performed at Erlanger East. The Primary Health System also recorded a deferred liability in the amount of $1,900,000 that will be amortized (and recognized as operating revenue) over the lease term of 20 years.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Notes to Combined Financial Statements

Years Ended June 30, 2013 and 2012

NOTE A–SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity: The Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System (the Primary Health System) was created by a private act passed by the General Assembly of the State of Tennessee on March 11, 1976, and adopted by a majority of the qualified voters of Hamilton County, Tennessee on August 5, 1976. The Chattanooga-Hamilton County Hospital Authority consists of the Primary Health System and its aggregate discretely presented component units as disclosed below.

The Primary Health System provides comprehensive healthcare services throughout Hamilton and Bledsoe counties, as well as outlying areas in southeastern Tennessee and north Georgia. These services are provided primarily through the hospital and other facilities located on the Baroness campus of Erlanger Medical Center. The Primary Health System also operates other hospitals and clinics throughout the area. The Primary Health System is considered the primary governmental unit for financial reporting purposes. As required by accounting principles generally accepted in the United States of America, these combined financial statements present the Primary Health System and its component units. The component units discussed below are included in the Primary Health System's reporting entity because of the significance of their operational or financial relationships with the Primary Health System.

The primary mission of the Primary Health System and its component units is to provide healthcare services to the citizens of Chattanooga, Hamilton County and the surrounding area. Only those activities directly associated with this purpose are considered to be operating activities. Other activities that result in gains or losses unrelated to the Primary Health System's primary mission are considered to be nonoperating.

Erlanger Health Plan Trust, Plaza Surgery, G.P., ContinuCare HealthServices, Inc., Cyberknife of Chattanooga, LLC, and UT-Erlanger Medical Group, Inc. are legally separate organizations which the Primary Health System has determined are component units of the Primary Health System.

Blended Component Units: The financial statements of Erlanger Health Plan Trust are blended with the Primary Health System in the basic combined financial statements as the board of Erlanger Health Plan Trust is substantially the same as that of the Primary Health System and the Primary Health System has operational responsibility.

Plaza Surgery, G.P. (Plaza) operated an ambulatory surgery center on the Primary Health System's campus. In 2012, the Primary Health System purchased the remaining outstanding units of Plaza and its operations are no longer distinct from the Primary Health System, although Plaza remains a separate legal entity. The accompanying 2013 and 2012 combined financial statements reflect Plaza's operations, assets and liabilities as a blended component unit.

NOTE A--SIGNIFICANT ACCOUNTING POLICIES - Continued

Discretely Presented Component Units: The aggregate discretely presented component units column in the combined financial statements includes the financial data of the Primary Health System's other component units. They are reported in a separate column to emphasize that they are legally separate from the Primary Health System. See the combined, condensed financial information in Note Q.

1. ContinuCare HealthServices, Inc. and subsidiary (ContinuCare) provide health and supportive services to individuals in their homes in the Hamilton County and north Georgia areas. ContinuCare also provides retail pharmacy goods and services at four locations in Hamilton County. The Primary Health System owns 100% of the stock of ContinuCare. Separately audited financial statements for ContinuCare HealthServices, Inc. may be obtained by mailing a request to 1501 Riverside Drive, Suite 140, Chattanooga, Tennessee 37406.

   ContinuCare owes the Primary Health System for various services, supplies, and rents provided, or expenses paid on its behalf. Actual expenses incurred related to these services were $2,119,466 and $1,728,869 in 2013 and 2012, respectively, including management fees of approximately $33,000 each year. In addition, ContinuCare provides staffing, contract nurse visits, and administrative services to the Primary Health System. Revenues from such services were $617,427 and $508,888 for the years ended 2013 and 2012, respectively. Amounts due at June 30, 2013 and 2012 are included in amounts due to/from other governments in the accompanying combined financial statements.

2. Cyberknife of Chattanooga, LLC (Cyberknife) provides radiation therapy services, specifically robotic stereotactic radiosurgical services, through the use of a cyberknife stereotactic radiosurgery system on the Primary Health System's campus. At June 30, 2013 and 2012 the Primary Health System owns 51% of Cyberknife's outstanding membership units and Cyberknife is fiscally dependent on the Primary Health System.

   During fiscal year 2011, Cyberknife was capitalized by the contribution of the Primary Health System of $612,000 and the contribution of cash from certain minority partners of $588,000. In addition to the capital contributions, each Member is required as a condition precedent to such Member's admission as a Member of Cyberknife, to deliver limited guaranties, guaranteeing prorata repayment of indebtedness of Cyberknife incurred to finance its equipment costs and its working capital needs. As of June 30, 2013 and 2012, total debt outstanding was $3,916,667 and $4,416,667 respectively. Income is allocated to Members based on ownership percentages and taxed at the Member level based upon the tax status of the partner. The portion of

NOTE A–SIGNIFICANT ACCOUNTING POLICIES - Continued

income allocated to the Primary Health System is exempt from income taxes based on the Primary Health System's tax-exempt status.

As of June 30, 2013 and 2012, Cyberknife owes the Primary Health System for various services, supplies and rents provided, or expenses paid on its behalf. The Primary Health System owes Cyberknife for radiation services provided by Cyberknife to the Primary Health System's patients. Revenues related to those services provided to the Primary Health System were $1,560,900 and $1,595,300 in 2013 and 2012, respectively. Amounts due at June 30, 2013 and 2012 are included in amounts due to/from other governments in the accompanying combined statements of net position.

3. UT-Erlanger Medical Group, Inc. (the Medical Group) was formed on June 30, 2011 and will provide professional healthcare and related services to the public through employed and contracted licensed physicians and other supporting healthcare providers. The Medical Group is not yet active. The Medical Group has no members; however, the Primary Health System may access the Medical Group's services. The Primary Health System is not entitled to any potential earnings of the Medical Group except for compensation for services rendered to the Medical group on its behalf. However, based upon the significance of the Medical Group's operation to the Primary Health System, management believes its exclusion would be misleading and as such, includes the Medical Group as a component unit.

Erlanger Health System Foundations (the Foundation): The Foundation assists the Primary Health System to promote and develop charitable and educational opportunities as they relate to healthcare services provided by the Primary Health System. The Primary Health System is not financially accountable for the Foundation and as a result the Foundation has not been included in the combined financial statements.

Contributions from the Foundation totaling approximately $920,395 and $494,000 for the years ended June 30, 2013 and 2012, respectively, were recognized as contribution revenue by the Primary Health System.

Use of Estimates: The preparation of the combined financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the combined financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

NOTE A–SIGNIFICANT ACCOUNTING POLICIES - Continued

Enterprise Fund Accounting: The Primary Health System and its blended component units utilize the enterprise fund method of accounting whereby revenue and expenses are recognized on the accrual basis using the economic resources measurement focus. In December 2010, the Governmental Accounting Standards Board (GASB) issued Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 Financial Accounting Standards Board (FASB) and American Institute of Certified Public Accountants (AICPA) Pronouncements*. This Statement incorporates into the GASB's authoritative literature certain accounting and financial reporting guidance that is included in the following pronouncements issued on or before November 30, 1989, and which does not conflict with or contradict GASB pronouncements: FASB Statements and Interpretations; Accounting Principles Board Opinions; and Accounting Research Bulletins of the AICPA Committee on Accounting Procedure. This Statement also supersedes Statement No. 20, *Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*, thereby eliminating the election provided in paragraph 7 of that Statement for enterprise funds and business-type activities to apply post-November 30, 1989 FASB Statements and Interpretations that do not conflict with or contradict GASB pronouncements.

Recently Issued or Effective Accounting Pronouncements: In November 2010, the GASB issued Statement No. 61, *The Financial Reporting Entity: Omnibus* (GASB 61). The Statement is effective for financial statement periods beginning after June 15, 2012 and amends Statement No. 14, *The Financial Reporting Entity*, and the related financial reporting requirements of Statement No. 34, *Basic Financial Statements—and Management's Discussion and Analysis - for State and Local Governments.* This Statement modifies certain requirements for inclusion of component units in the financial reporting entity and amends the criteria for reporting component units as if they were part of the primary government in certain circumstances. The Primary Health System adopted GASB 61 in fiscal year 2013. The impact of the adoption resulted in the Primary Health System recognizing its investment in Cyberknife and ContinuCare on the combined statement of net position and recognition of its share of gains or losses on these entities in the combined statements of revenue, expenses and changes in net position. The 2012 combined financial statements have been restated to comply with GASB 61 and the cumulative effect of a change in accounting principle is included in the combined statement of revenue, expenses and changes in net position to reflect the Primary Health System's cumulative investment in these entities as of July 1, 2011.

In June 2011, the GASB issued Statement No. 63, *Financial Reporting of Deferred Outflows of Resources, Deferred Inflows of Resources, and Net Position.* This Statement amends the net asset reporting requirements of GASB Statement No. 34 and other pronouncements by incorporating deferred outflows and inflows of resources into the definitions of the required components of the residual measure and renaming that measure as net position, rather than net

NOTE A--SIGNIFICANT ACCOUNTING POLICIES - Continued

assets. The requirements of this Statement were adopted by the Primary Health System in fiscal year 2013 and the adoption did not have a material impact on the combined financial statements.

In March 2012, the GASB issued Statement No. 65, *Items Previously Reported as Assets and Liabilities*. Statement No. 65 establishes reporting standards that reclassify items previously reported as assets or liabilities as deferred inflows or outflows. This Statement will be effective for the Primary Health System in 2014 and management is currently evaluating its impact on the combined financial statements.

In June 2012, the GASB issued Statement No. 68, *Accounting and Financial Reporting for Pensions*. Statement No. 68 provides guidance for improved accounting and financial reporting by state and local government entities related to pensions. It also replaces the requirements of GASB Statement No. 27 and Statement No. 50, as they relate to pensions that are provided through pension plans administered as trusts or equivalent arrangements that meet certain criteria. This Statement is required for fiscal years beginning after June 15, 2014 with early adoption encouraged. This Statement will be effective for the Primary Health System in 2015 and management is currently evaluating its impact on the combined financial statements.

Net Patient Service Revenue/Receivables: Net patient service revenue is reported on the accrual basis in the period in which services are provided at rates which reflect the amount expected to be collected. Net patient service revenue includes amounts estimated by management to be reimbursable by third-party payer programs under payment formulas in effect. Net patient revenue also includes an estimated provision for bad debts based upon management's evaluation of collectability based upon the age of the receivables and other criteria, such as payer classification and management's assumptions about conditions it expects to exist and courses of action it expects to take. The Primary Health System's policies do not require collateral or other security for accounts receivable, although the Primary Health System routinely accepts assignment or is otherwise entitled to receive patient benefits payable under health insurance programs, plans or policies. Supplemental payments from the State of Tennessee are recognized when determinable (see Note B).

Charity Care: The Primary Health System accepts patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain policies established by the County Auditor with regard to the Hamilton County indigent program or by the Primary Health System for other patients. Essentially, these policies define charity services as those services for which minimal payment is anticipated. In assessing a patient's inability to pay, the County and the Primary Health System utilize the generally recognized poverty income levels, but also include certain cases where incurred charges are significant when compared to the income of the patient. These charges are not included in net patient service revenue.

NOTE A--SIGNIFICANT ACCOUNTING POLICIES - Continued

Inventories: Inventories consist principally of medical and surgical supplies, general store supplies, and pharmacy items and are stated at lower of cost (first-in, first-out) or fair market value.

Cash Equivalents: The Primary Health System considers all highly liquid investments with maturities of three months or less when purchased, excluding amounts whose use is limited by board designation, held by trustees under indenture agreement, or otherwise restricted as to use, to be cash equivalents.

Investments: The Primary Health System's investments (including assets limited as to use) are reported at fair market value based on quoted market prices in accordance with GASB Statement No. 31, *Accounting and Financial Reporting for Certain Investments and for External Investment Pools.* Assets limited as to use include funds designated by the Board, funds held by trustees under trust indentures, and funds restricted by donors or grantors for specific purposes. The Primary Health System considers those investments with maturities of more than three months when purchased, maturing in more than one year and whose use is not limited by board designation, held by trustees under indenture agreement, or otherwise restricted as to use, to be long-term investments. Investments, including assets limited as to use, consist of United States government, government agency and municipal bonds, corporate debt and other short-term investments.

Temporary Investments: The Primary Health System considers all highly liquid investments with maturities of more than three months when purchased and maturing in less than one year, excluding amounts whose use is limited by board designation, held by trustees under indenture agreement, or otherwise restricted as to use, to be temporary investments. Temporary investments consist primarily of United States government agency bonds, municipal bonds and commercial paper.

Derivative Instruments: The Primary Health System records all derivatives as assets or liabilities on the combined statements of net position at estimated fair value and includes credit value adjustments. The Primary Health System's derivative holdings consist of interest rate swap agreements. Since these derivatives have not been determined to be effective the gain or loss resulting from changes in the fair value of the derivatives is recognized in the accompanying combined statements of revenue, expenses and changes in net position. The Primary Health System's objectives in using derivatives are to take advantage of the differences between taxable and tax-exempt debt, and manage exposure to interest rate risks associated with various debt instruments (see Note N).

NOTE A--SIGNIFICANT ACCOUNTING POLICIES - Continued

Net Property, Plant and Equipment: Property, plant and equipment is recorded on the basis of cost. Donated assets are recorded at their fair market value at the date of donation. Leases that are substantially installment purchases of property are recorded as assets and amortized over their estimated useful lives ranging from three to thirty years; related amortization is included in depreciation expense. Depreciation expense is computed over estimated service lives of the respective classes of assets using the straight-line method. The Primary Health System has established a capitalization threshold for property, plant and equipment of $2,500 except for computer equipment, which has a threshold of $1,000. Interest expense and interest income on borrowed funds related to construction projects are capitalized during the construction period, if material. Costs of maintenance and repairs are charged to expense as incurred.

The Primary Health System previously adopted the provisions of GASB Statement No. 42, *Accounting and Financial Reporting for Impairment of Capital Assets and for Insurance Recoveries*, which establishes accounting and financial reporting standards for impairment of capital assets. A capital asset is considered impaired when its service utility has declined significantly and unexpectedly. The Primary Health System did not experience any prominent events or changes in circumstances affecting capital assets which would require determination as to whether impairment of a capital asset has occurred during the years ended June 30, 2013 and 2012.

Compensated Absences: The Primary Health System recognizes an expense and accrues a liability for employees' paid annual leave and extended illness benefits in the period in which the employees' right to such compensated absences are earned. Liabilities expected to be paid within one year are included as accrued salaries and related liabilities in the accompanying combined statements of net position.

Deferred Financing Costs: Deferred financing costs consist principally of costs associated with bond issues and are being amortized, generally, over the terms of the respective debt issues by the effective interest method.

Income Taxes: The Primary Health System is exempt from income taxes under Section 501(a) as an organization described in Section 501(c)(3) of the Internal Revenue Code (IRC). In addition, it qualifies for exemption from federal income taxes pursuant to IRC Section 115 as an instrumentality of the State of Tennessee. Therefore, no provision for income taxes has been recognized in the accompanying combined financial statements for the Primary Health System. Tax returns for the years ended June 30, 2010 through 2013 are subject to examination by taxing authorities.

NOTE A--SIGNIFICANT ACCOUNTING POLICIES - Continued

As a for-profit entity, ContinuCare is subject to state and federal income taxes. ContinuCare HealthServices, Inc. and its subsidiary file consolidated federal income tax returns separately from the Primary Health System. At June 30, 2013 and 2012, ContinuCare had no significant uncertain tax positions. Tax returns for the years ended June 30, 2008 through 2013 are subject to examination by taxing authorities.

As a Limited Liability Corporation, Cyberknife, a discretely presented component unit, is subject to State of Tennessee income taxes. At June 30, 2013 and 2012, Cyberknife had no significant uncertain tax positions. Tax returns for the years ended June 30, 2010 through 2013 are subject to examination by taxing authorities.

Contributed Resources: Resources restricted by donors for specific operating purposes are held as restricted funds and are recognized as operating or capital contributions in the accompanying combined financial statements. When expended for the intended purpose, they are reported as operating distributions and are recognized as other operating revenue. Contributed resources consist of amounts restricted by donors for specific purposes. Fundraising expenses are netted against contributions recognized.

Net Position: The net position of the Primary Health System is classified into three components. *Net investment in capital assets* consists of capital and other assets net of accumulated depreciation and reduced by the current balances of any outstanding borrowings used to finance the purchase or construction of those assets. The *restricted expendable* net position consists of assets that must be used for a particular purpose that are either externally imposed by creditors, grantors, contributors or laws or regulations of other governments or imposed by law through constitutional provisions or enabling legislation. *The unrestricted net position* is remaining assets that do not meet the definition of *net investment in capital assets* or *restricted expendable.*

Fair Value of Financial Instruments: The carrying amounts reported in the combined statements of net position for cash, accounts receivable, investments, accounts payable and accrued expenses approximate fair value.

The carrying value of long-term debt and capital lease obligations (including the current portion) was $177,428,798 as of June 30, 2013 and $185,240,524 as of June 30, 2012. The estimated fair value of long-term debt and capital lease obligations (including current portion) was $186,227,537 and $194,322,333 as of June 30, 2013 and 2012, respectively. The fair value of long-term debt related to fixed interest long-term debt and capital lease obligations was estimated using discounted cash flows, based on the Primary Health System's incremental borrowing rates or from quotes obtained from investment advisors. The fair value of long-term debt related to variable rate debt approximates its carrying value.

NOTE A--SIGNIFICANT ACCOUNTING POLICIES - Continued

Subsequent Events: The Primary Health System evaluated all events or transactions that occurred after June 30, 2013 through September 17, 2013, the date the combined financial statements were available to be issued. Management did not note any material recognizable subsequent events that required recognition or disclosure in the June 30, 2013 combined financial statements other than an agreement reached with the University of Tennessee College of Medicine (UTCOM) in September 2013 to reimburse the Primary Health System approximately $2,300,000 related to a refund of employment taxes in fiscal year 2013 to UTCOM by the Internal Revenue Service. The Primary Health System had previously reimbursed UTCOM for these expenses. The amount was recognized as a receivable at June 30, 2013 in the combined statement of net position and as a reduction of salaries, wages and benefits expense in the combined statement of revenues, expenses and changes in net position.

Reclassifications: In addition to the adoption of GASB 61, discussed previously, certain reclassifications have been made to the 2012 combined financial statements to conform with the 2013 combined financial statement presentation.

NOTE B--NET PATIENT SERVICE REVENUE

A reconciliation of the amount of services provided to patients at established rates by the Primary Health System to net patient service revenue as presented in the combined statements of revenue, expenses and changes in net position for the years ended June 30, 2013 and 2012 is as follows:

	Primary Health System	
	2013	*2012*
Inpatient service charges	$ 986,725,639	$ 1,007,816,189
Outpatient service charges	706,628,068	657,002,015
Gross patient service charges	1,693,353,707	1,664,818,204
Less: Contractual adjustments and other discounts	991,945,605	974,199,369
Charity care	101,729,252	77,554,683
Estimated provision for bad debts	73,539,550	98,982,459
	1,167,214,407	1,150,736,511
Net patient service revenue	$ 526,139,300	$ 514,081,693

Charity Care and Community Benefit: The Private Act of the State of Tennessee establishing the Primary Health System obligates the Primary Health System to make its facilities and patient care programs available to the indigent residents of Hamilton County to the extent of funds appropriated by Hamilton County and adjusted operating profits, as defined. The annual

NOTE B--NET PATIENT SERVICE REVENUE - Continued

appropriation from Hamilton County was not to be less than $3,000,000 in each fiscal year without approval of the Primary Health System, so long as the 1966 Hamilton County Sales Tax Agreement remains in effect. The Sales Tax Agreement expired in May 2011 which resulted in a $1,500,000 reduction for fiscal year 2013 and 2012. Total charity care charges for services provided to the certified indigent residents of Hamilton County (net of the appropriation) were approximately $23,757,000 and $23,387,000 for the years ended June 30, 2013 and 2012 for the Primary Health System.

In addition to charity care provided to specific patients within the hospital setting, the Primary Health System also provides unreimbursed services to the community which includes free and low cost health screenings. The Primary Health System also hosts health fairs and helps sponsor many other events that are free to the public and are spread throughout the year in various community locations.

The Primary Health System's Community Relations department, which conducts health, wellness, safety education classes and health screenings, includes Erlanger HealthLink Plus, a free adult membership program with over 15,000 members in the Chattanooga Statistical Metropolitan Service Area. The program provides over 16 classes and/or screenings and fitness opportunities per month that are free or at a low cost to members and to the community. These classes and screenings are held in two primary locations with additional classes at satellite locations in the region. As part of Community Relations, Safe & Sound, an injury prevention service of Children's Hospital, offers free educational events regarding childhood injury prevention, including free car seat inspection and installation workshops. The Community Relations program utilizes the services of physicians, nurses, volunteers, educators, registered dietitians, social workers, secretaries and management personnel of the Primary Health System.

The Primary Health System's consumer call center, Erlanger HealthLink (423-778-LINK) is a free call center staffed by RN's to answer health questions, offer free physician referrals and to register participants in the programs offered by Community Relations, Women's & Infant Services and other departments and divisions of the Primary Health System.

Uncompensated Care Costs: The following table summarizes the estimated total uncompensated care costs provided by Erlanger Medical Center as defined by the State of Tennessee for the years ended June 30, 2013 and 2012:

NOTE B--NET PATIENT SERVICE REVENUE - Continued

	2013	2012
Uncompensated cost of TennCare/Medicaid	$ 28,228,719	$ 27,864,201
Traditional charity uncompensated costs	33,423,115	25,568,279
Bad debt cost	23,429,117	32,074,717
Total uncompensated care costs	$ 85,080,951	$ 85,507,197

The uncompensated cost of TennCare/Medicaid is estimated by taking the estimated cost of providing care to the TennCare/Medicaid patients less payments from the TennCare and Medicaid programs. The payments exclude revenues from essential access and other, one-time supplemental payments from TennCare of approximately $10,615,000 and $11,359,300 for the years ended June 30, 2013 and 2012, respectively, as such payments are not guaranteed for future periods. Traditional charity uncompensated costs exclude approximately $1,500,000 of local government support annually in 2013 and 2012.

Revenue from Significant Payers: Gross patient service charges related to the Medicare program accounted for approximately 29.6% and 29.7% of the Primary Health System's patient service charges for the years ended June 30, 2013 and 2012, respectively. Gross patient service charges related to the TennCare/Medicaid programs accounted for approximately 24.1% and 24.8% of the Primary Health System's patient service charges for the years ending June 30, 2013 and 2012, respectively. TennCare typically reimburses providers at an amount less than their cost of providing services to TennCare patients. At June 30, 2013 and 2012, the Primary Health System has a credit concentration related to the Medicare and TennCare programs.

During 2013 and 2012, the Primary Health System recognized revenue from these programs related to disproportionate share payments and trauma fund payments of $9,622,000 and $10,176,000, respectively. During 2013 and 2012, the Primary Health System also recognized approximately $2,667,000 and $3,100,000, respectively, of revenue related to electronic health records expenditures reimbursed by the Medicare and Medicaid programs. Such amounts are subject to audit. Additionally, in 2012, the Primary Health System received approximately $3,200,000 from Medicare related to a rural floor budget neutrality settlement that has been recognized as net patient revenue.

Laws and regulations governing the Medicare and TennCare/Medicaid programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates, as they relate to revenue recognized from these programs, will change by a material amount in the near term. The estimated reimbursement amounts are adjusted in subsequent

NOTE B--NET PATIENT SERVICE REVENUE - Continued

periods as cost reports are prepared and filed and as final settlements are determined. Final determination of amounts earned under prospective payment and cost reimbursement activities is subject to review by appropriate governmental authorities or their agents. Management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under Medicare and Medicaid programs. The effect of prior year cost report settlements, or changes in estimates, increased net patient service revenue by approximately $2,163,000 in 2013 and by approximately $1,770,000 in 2012.

The Primary Health System believes that it is substantially in compliance with all applicable laws and regulations. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers, such as the Medicare Recovery Audit Contractor Program. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time. Management believes that any amounts payable related to audits through the Medicare Recovery Audit Contractor program, or similar initiatives, will not have a significant impact on the combined financial statements. However, due to the uncertainties involved, management's estimate could change in the future.

The Primary Health System has also entered into reimbursement agreements with certain commercial insurance companies, health maintenance organizations and preferred provider organizations. The basis for reimbursement under these agreements includes prospectively determined rates, per diems and discounts from established charges.

NOTE C--CASH AND CASH EQUIVALENTS

Cash and cash equivalents reported on the combined statements of net position include cash on hand and deposits with financial institutions including demand deposits and certificates of deposit.

The carrying amount of cash and cash equivalents consists of the following at June 30:

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Notes to Combined Financial Statements - Continued

Years Ended June 30, 2013 and 2012

NOTE C--CASH AND CASH EQUIVALENTS - Continued

	Primary Health System	
	2013	*2012*
General Fund:		
Demand deposits	$ 15,087,535	$ 25,703,339
Cash on hand	9,904	10,254
Cash equivalents	2,153,466	2,106,876
	$ 17,250,905	$ 27,820,469

Cash equivalents include certificates of deposit, money market accounts, U.S. Government agency investments and commercial paper whose maturity, when purchased, was three months or less.

Bank balances consist of the following at June 30:

	Primary Health System	
	2013	*2012*
Insured (FDIC)	$ 622,493	$ 3,770,196
Collateralized under the State of Tennessee Bank Collateral Pool	21,221,755	20,008,446
Other	272,275	-
	$ 22,116,523	$ 23,778,642

In addition to the above bank balances, the Primary Health System held investments which met the definition of a cash equivalent and are included in cash and cash equivalents. At June 30, 2013 and 2012, amounts totaling $2,153,466 and $2,106,876 respectively, were invested in U.S. Government agency obligations and commercial paper.

Through December 31, 2010, the Primary Health System maintained bank balances with certain financial institutions which participated in the Federal Deposit Insurance Corporation (FDIC) Transaction Account Guarantee (TAG) Program. The TAG program expired on December 31, 2010, with the Dodd-Frank Deposit Insurance Provision becoming effective through December 31, 2012. Under the Dodd-Frank Deposit Insurance Provision, all non-interest bearing transaction accounts held by FDIC-insured depository institutions are fully insured by the FDIC for the entire balance of the account. On December 31, 2012 the Dodd-Frank Insurance Provisions expired and as of June 30, 2013, FDIC insurance was $250,000 per account holder, per bank.

NOTE C--CASH AND CASH EQUIVALENTS - Continued

The Primary Health System's deposits would be exposed to custodial credit risk if they are not covered by depository insurance and the deposits are uncollateralized or are collateralized with securities held by the pledging financial institution's trust department or agent but not in the depositor government's name. The risk is that, in the event of the failure of a depository financial institution, the Primary Health System will not be able to recover deposits or will not be able to recover collateral securities that are in the possession of an outside party.

NOTE D--DISAGGREGATION OF RECEIVABLE AND PAYABLE BALANCES

Patient Accounts Receivable, Net: Patient accounts receivable and related allowances are as follows at June 30:

	Primary Health System	
	2013	*2012*
Gross patient accounts receivable	$ 270,824,481	$ 296,701,066
Estimated allowances for contractual adjustments and uncollectible accounts	(197,262,812)	(220,059,628)
Net patient accounts receivable	$ 73,561,669	$ 76,641,438

Other Current Assets: Other current assets consist of the following at June 30:

	Primary Health System	
	2013	*2012*
Prepaid expenses	$ 5,205,938	$ 5,000,884
Other receivables	14,923,382	19,382,671
Total other current assets	$ 20,129,320	$ 24,383,555

Accounts Payable and Accrued Expenses: Accounts payable and accrued expenses consist of the following at June 30:

	Primary Health System	
	2013	*2012*
Due to vendors	$ 44,847,075	$ 33,759,165
Other	2,098,648	2,999,537
Total accounts payable and accrued expenses	$ 46,945,723	$ 36,758,702

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Notes to Combined Financial Statements - Continued

Years Ended June 30, 2013 and 2012

NOTE D--DISAGGREGATION OF RECEIVABLE AND PAYABLE BALANCES - Continued

Other Long-Term Liabilities: Other long-term liabilities consist of the following at June 30:

	Primary Health System	
	2013	*2012*
Pension obligation	$ 10,439,507	$ 10,547,623
Postretirement benefits other than pensions	5,921,563	4,851,114
Compensated absences	6,567,615	7,019,203
Medical malpractice and general liabilities	4,985,000	5,462,500
Interest rate swaps	4,856,429	7,112,464
Deferred gain on sale of property	4,400,481	4,865,237
Other	4,620,389	1,539,104
Total other long-term liabilities	$ 41,790,984	$ 41,397,245

NOTE E--NET PROPERTY, PLANT AND EQUIPMENT

Net property, plant and equipment activity for the Primary Health System for the years ended June 30, 2013 and 2012 consisted of the following:

	Balance at June 30, 2011	*Additions*	*Reductions/ Transfers*	*Balance at June 30, 2012*	*Additions*	*Reductions/ Transfers*	*Balance at June 30, 2013*
Capital assets:							
Land and improvements	$ 26,883,511	$ 385,757	$ 1,913,362	$ 25,355,906	$ 298,962	$ -	$ 25,654,868
Buildings	243,445,965	9,082,187	28,652,217	223,875,935	6,845,858	-	230,721,793
Equipment	357,235,297	21,779,957	28,498,593	350,516,661	20,581,177	4,240,082	366,857,756
	627,564,773	31,247,901	59,064,172	599,748,502	27,725,997	4,240,082	623,234,417
Accumulated depreciation :							
Land and improvements	12,552,092	589,770	1,916,632	11,225,230	398,356	-	11,623,586
Buildings	176,624,223	7,720,427	22,551,870	161,792,780	7,808,629	319,543	169,281,866
Equipment	285,520,631	17,931,412	27,664,817	275,787,226	18,649,088	3,692,069	290,744,245
	474,696,946	26,241,609	52,133,319	448,805,236	26,856,073	4,011,612	471,649,697
Capital assets net of accumulated depreciation	152,867,827	5,006,292	6,930,853	150,943,266	869,924	228,470	151,584,720
Construction in progress ($11,366,347 estimated cost to complete at June 30, 2013)	10,463,103	16,548,309	20,236,515	6,774,897	24,935,626	22,321,668	9,388,855
	$ 163,330,930	$ 21,554,601	$ 27,167,368	$ 157,718,163	$ 25,805,550	$ 22,550,138	$ 160,973,575

Depreciation expense totaled $26,856,073 and $26,241,609 for the years ended June 30, 2013 and 2012, respectively. Construction in progress at June 30, 2013 consists of various projects for additions and renovations to the Primary Health System's facilities.

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Notes to Combined Financial Statements - Continued

Years Ended June 30, 2013 and 2012

NOTE E--NET PROPERTY, PLANT AND EQUIPMENT - Continued

During 2012, the Primary Health System entered into an agreement to sell certain professional office buildings (POBs) and concurrently entered into agreements to lease space from the purchaser. The sales price of the POBs was approximately $13,333,000, and a gain of approximately $6,695,000 was realized, including proceeds of approximately $2,355,000 held back until such time as certain of the leases are finalized. The amount held back is included as other current assets in the combined statement of net position at June 30, 2012 and was received during the year ended June 30, 2013.

Since the Primary Health System is leasing back certain space, accounting principles generally accepted in the United States required a portion of the gain be deferred and recognized over the terms of the leases. At June 30, 2013 and 2012, the deferred gain totaled approximately $4,400,000 and $4,865,000, respectively and is included as a part of other long-term liabilities in the accompanying combined statements of net position. Amortization of the deferred gain is included in non-operating revenue (expenses) for the years ended June 30, 2013 and 2012.

The leases entered into (or committed to) under this sale/leaseback agreement include certain leases which meet the criteria for capitalization and are included in Note M.

NOTE F--INVESTMENTS AND ASSETS LIMITED AS TO USE

The Primary Health System's investments (including assets limited as to use) are reported at estimated fair value based, generally, on quoted market prices in accordance with GASB Statement No. 31, *Accounting and Financial Reporting for Certain Investments and for External Investment Pools.* The Primary Health System invests in United States government and agency bonds, municipal bonds, corporate debt, certificates of deposit and short-term money market investments that are in accordance with the Primary Health System's investment policy. Temporary investments at June 30, 2013 and 2012 consist primarily of United States government agency bonds, state and local government bonds and commercial paper.

The carrying and estimated fair values for long-term investments, and assets limited as to use, by type, at June 30 are as follows:

	Primary Health System	
	2013	*2012*
U.S. Government and agency bonds, including municipal bonds, mutual funds, and other	$ 111,569,814	$ 119,596,675
Corporate bonds and commercial paper	4,348,798	940,586
Short-term investments and cash equivalents	16,131,637	18,177,563
Total investments and assets limited as to use	$ 132,050,249	$ 138,714,824

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Notes to Combined Financial Statements - Continued

Years Ended June 30, 2013 and 2012

NOTE F--INVESTMENTS AND ASSETS LIMITED AS TO USE - Continued

Assets limited as to use are classified as follows:

	Primary Health System	
	2013	*2012*
By board of trustees for capital improvements	$ 99,572,404	$ 108,023,256
Under bond indentures - held by trustees	20,901,235	20,900,048
Self-insurance trust	6,318,010	6,089,183
Restricted by donors and other	3,467,654	3,439,941
	130,259,303	138,452,428
Less current portion	(28,275)	(33,250)
Total assets whose use is limited	$ 130,231,028	$ 138,419,178

Assets limited as to use by the board of trustees for capital improvements are to be used for the replacement of property and equipment or for any other purposes so designated.

Funds held by trustees under bond indenture at June 30 are as follows:

	Primary Health System	
	2013	*2012*
Debt service reserve funds	$ 20,718,915	$ 20,712,768
Principal and interest funds	28,275	33,250
Other funds	154,045	154,030
Total funds held by trustees under bond indenture	$ 20,901,235	$ 20,900,048

These funds held by trustees consist primarily of United States government agency obligations, state and local government obligations, corporate debt, and other short-term investments and cash equivalents. The debt service reserve fund is to be used only to make up any deficiencies in other funds related to the Hospital Revenue and Refunding Bonds Series 1997A, Series 1998A, Series 2000 and Series 2004. The principal and interest funds are to be used only to pay principal and interest, respectively, on the Series 1997A, Series 1998A, Series 2000 and Series 2004 bonds.

The Primary Health System has implemented the disclosure requirements of GASB Statement No. 40, *Deposit and Investment Risk Disclosures* (GASB No. 40) and, accordingly, the Primary Health System has assessed the custodial credit risk, the concentration of credit risk, credit risk,

NOTE F--INVESTMENTS AND ASSETS LIMITED AS TO USE - Continued

and investment rate risk of its cash and investments. The Primary Health System's investment policy specifies the types of investments which can be included in board-designated assets limited as to use, as well as collateral or other security requirements. The investment policy also specifies the maximum maturity of the portfolio of board-designated assets. Assets limited as to use and held by trustees are invested as permitted by the bond indenture.

Custodial Credit Risk: The Primary Health System's investment securities are exposed to custodial credit risk if the securities are uninsured, are not registered in the name of the Primary Health System, and are held by either the counterparty or the counterparty's trust department or agent but not in the Primary Health System's name. The investment risk is that, in the event of the failure of the counterparty to a transaction, the Primary Health System will not be able to recover the value of the investment or collateral securities that are in the possession of an outside party.

As of June 30, 2013 and 2012, the Primary Health System's investments, including assets limited as to use, were comprised of various short-term investments, U.S. government and government agency bonds, municipal obligations, corporate bonds, commercial paper, and other U.S. Treasury obligations. Substantially all of the Primary Health System's investments, including assets limited as to use, are uninsured or unregistered. Securities are held by the counterparty, or by its trust department or agent, in the Primary Health System's name.

Concentration of Credit Risk: This is the risk associated with the amount of investments the Primary Health System has with any one issuer that exceeds 5% or more of its total investments. Investments issued or explicitly guaranteed by the U.S. Government and investments in mutual funds, external investment pools, and other pooled investments are excluded from this requirement. The Primary Health System's investment policy does not restrict the amount that may be held for any single issuer. At June 30, 2013, none of the Primary Health System's investments with any one issuer exceed 5% of its total investments except certain U.S. Government agencies.

Credit Risk: This is the risk that an issuer or other counterparty to an investment will not fulfill its obligations. GASB No. 40 requires that disclosure be made as to the credit rating of all debt security investments except for obligations of the U.S. Government or obligations explicitly guaranteed by the U.S. Government. The Primary Health System's investment policy provides guidelines for its fund managers and lists specific allowable investments.

The credit risk profile of the Primary Health System's investments, including assets limited as to use (excluding U.S. Government securities), as of June 30, 2013, is as follows:

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Notes to Combined Financial Statements - Continued

Years Ended June 30, 2013 and 2012

NOTE F--INVESTMENTS AND ASSETS LIMITED AS TO USE - Continued

		Rating					
Investment Type	*Balance as of June 30, 2013*	*AAA*	*AA*	*A*	*BBB*	*BB*	*N/A*
U.S Government agency bonds	$ 41,071,080	$ 39,483,550	$ 1,587,530	$ -	$ -	$ -	$ -
Bond mutual funds and other	5,618,901	5,618,901	-	-	-	-	-
Municipal bonds	6,747,750	1,540,570	4,200,440	1,006,740	-	-	-
Corporate bonds and commercial paper	4,348,798	3,004,200	-	1,344,598	-	-	-
Cash equivalents	16,153,954	-	-	-	-	-	16,153,954
Total investments	$ 73,940,483	$ 49,647,221	$ 5,787,970	$ 2,351,338	$ -	$ -	$ 16,153,954

Investment Rate Risk: This is the risk that changes in interest rates will adversely affect the fair value of an investment. The Primary Health System's investment policy authorizes a strategic asset allocation that is designed to provide an optimal return over the Primary Health System's investment horizon and within specified risk tolerance and cash requirements.

The distribution of the Primary Health System's investments, including assets limited as to use, and excluding the self-insurance trust, by maturity as of June 30, 2013, is as follows:

		Remaining Maturity				
Investment Type	*Balance as of June 30, 2013*	*12 months or less*	*13-24 Months*	*25-60 Months*	*Over 60 Months*	*N/A*
U.S. Government bonds and agency funds and other	$ 103,283,374	$ 26,781,628	$ 19,349,742	$ 31,925,740	$ 25,226,264	$ -
Municipal bonds	5,298,686	-	3,324,586	1,974,100	-	-
Corporate bonds and commercial paper	4,348,798	4,348,798	-	-	-	-
Cash equivalents	12,801,381	12,801,381	-	-	-	-
Total investments	$ 125,732,239	$ 43,931,807	$ 22,674,328	$ 33,899,840	$ 25,226,264	$ -

Additionally, the distribution of the Primary Health System's investments held under the self-insurance trust as of June 30, 2013, is as follows:

		Remaining Maturity					
Investment Type	*Balance as of June 30, 2013*	*24 months or less*	*25-60 Months*	*61-120 Months*	*121-240 Months*	*Over 240 Months*	*N/A*
Bond Mutual Funds	$ 5,618,901	$ -	$ -	$ -	$ -	$ -	$ 5,618,901
Cash equivalents	699,109	699,109	-	-	-	-	-
Total investments	$ 6,318,010	$ 699,109	$ -	$ -	$ -	$ -	$ 5,618,901

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Notes to Combined Financial Statements - Continued

Years Ended June 30, 2013 and 2012

NOTE G--LONG-TERM DEBT

Long-term debt at June 30 consists of the following:

	Primary Health System	
	2013	*2012*
Revenue and Refunding Bonds, Series 2004, net of bond discount of $532,793 in 2013 and $684,990 in 2012 and including bond issue premium of $1,443,483 in 2013 and $1,584,311 in 2012	$ 71,955,690	$ 76,754,321
Hospital Revenue Refunding Bonds, Series 2000, including bond issue premium of $281,255 in 2013 and $304,215 in 2012	34,581,255	36,404,215
Hospital Revenue Bonds, Series 1998A, net of bond discount of $280,615 in 2013 and $295,384 in 2012	18,329,385	18,859,616
Hospital Revenue Bonds, Taxable Series 1997A	41,000,000	41,000,000
Total bonds payable	165,866,330	173,018,152
Less: unamortized premium paid on advance refunding	(809,251)	(895,189)
Total bonds payable, net	165,057,079	172,122,963
Other Loans and Notes Payable	5,630,515	6,282,894
Capital leases - Note M	6,741,204	6,834,667
	177,428,798	185,240,524
Less: current portion	(8,058,625)	(7,929,701)
	$ 169,370,173	$ 177,310,823

During fiscal year 2011, the Primary Health System entered into a term loan (the Loan) with a financial institution in the maximum amount of $7,000,000 to finance the acquisition of the Lifestyle Center property. The rate of interest on the loan is a fixed rate equal to 5.45%. Monthly payments of principal and interest are payable on the first day of each month for a 10 year term beginning December 1, 2010, with a final payment equal to the unpaid principal plus accrued and unpaid interest due at maturity. The loan contains certain covenants and restrictions. Management believes the Primary Health System was in compliance with all such covenants at June 30, 2013.

NOTE G--LONG-TERM DEBT - Continued

The Primary Health System entered into a non-revolving line of credit loan (the Credit Agreement) with a financial institution in the maximum amount of $41,000,000 to potentially refund the outstanding principal amount of the Primary Health System's 1997A Hospital Revenue Bonds if London InterBank Offered Rate (LIBOR) materially changes. The rate of interest on disbursed funds, if any, will be a variable rate equal to the London InterBank Offered Rate plus an applicable margin, as outlined in the Credit Agreement. Monthly installment payments of the outstanding principal amount, if any, shall be amortized over a period of seventeen years. As of June 30, 2013, the Primary Health System has not drawn on the Credit Agreement.

During fiscal year 2010, the Primary Health System remarketed the Series 2004 Hospital Revenue Refunding Bonds (Series 2004) and the Series 2000 Hospital Revenue Refunding Bonds (Series 2000), as described below, and converted such bonds from a variable auction rate to a fixed rate.

On January 1, 2004, the Primary Health System issued $85,000,000 insured Series 2004 bonds for the purpose of refunding $80,925,000 of the total outstanding Series 1993 bonds (described below). The Primary Health System also utilized the proceeds to pay certain issuance costs and contributed a portion of the bond proceeds in the amount of $1,633,658 to establish a debt service fund.

The Series 2004 bonds were issued on parity, with respect to collateral, with other outstanding bonds, described below. The Series 2004 bonds are also secured by a mortgage on a portion of the Primary Health System's main campus. The Series 2004 bonds mature annually on October 1 beginning in 2010 through 2023 in varying amounts. The Series 2004 bonds maturing after October 1, 2019 (excluding those maturing on October 1, 2023) may be redeemed by the Primary Health System after October 1, 2019 at a redemption price equal to the principal amount plus accrued interest. The bonds maturing on October 1, 2023 may be redeemed prior to maturity pursuant to the extraordinary optional redemption and redemption upon damage or condemnation provisions as described in the Remarketing Memorandum by the Primary Health System after October 1, 2014 at a redemption price equal to 100% of the principal amount plus accrued interest. Interest rates for the outstanding Series 2004 bonds range from 3.0% to 5.0%.

In August 2000, the Primary Health System issued $47,300,000 insured Series 2000 bonds for the purpose of refunding $40,000,000 of then outstanding Series 1987 bonds and funding a debt service reserve fund in an original amount of $4,407,377 and to pay issuance costs. The Series 2000 bonds were issued on parity with other outstanding bond issues. The Series 2000 bonds consist of term bonds maturing on October 1, 2023 and serial bonds maturing on October 1 annually beginning in 2010 through 2025. The bonds maturing on October 1, 2023 are subject to

NOTE G--LONG-TERM DEBT - Continued

mandatory sinking fund redemption prior to maturity and without premium at the principal amount thereof on October 1. The Series 2000 bonds maturing after October 1, 2014 may be redeemed by the Primary Health System after October 1, 2014 at a redemption price equal to the principal amount plus accrued interest.

Interest rates for the Series 2000 outstanding bonds are as follows:

Series Bonds	- 3.75% to 5.0%
Term Bonds	- 5.0%

The Primary Health System's 1997A and 1998A Hospital Revenue Bonds (Series 1997A and Series 1998A, respectively) were issued to fund capital improvements for Erlanger Medical Center and establish a debt service reserve fund (1998A only) in an original amount of $2,174,125. The Series 1997A bonds are taxable and are secured on a parity under a Master Trust Indenture with other outstanding bond issues. The bonds mature beginning in fiscal year 2015 through fiscal year 2028. The 1997A bonds are subject to optional redemption at 100% plus accrued interest. Interest is payable at a variable auction rate for a 35-day period, which was 0.49% at June 30, 2013 and 0.61% at June 30, 2012.

The Series 1998A insured bonds are tax-exempt and consisted of $6,080,000 serial bonds maturing annually on October 1 of each year through 2013 in varying amounts; and term bonds maturing on October 1, 2018 and 2028 ($5,825,000 and $17,095,000, respectively). Such bonds are secured on parity with other outstanding bonds. The bonds maturing after October 1, 2008 may be redeemed by the Primary Health System after April 1, 2008 at amounts ranging from 100% to 101% of par value plus accrued interest.

Interest rates for the outstanding Series 1998A bonds are as follows:

$ 6,080,000 Serial Bonds	- 4.75% to 5.00%
$ 5,825,000 Term Bonds	- 5.0%
$17,095,000 Term Bonds	- 5.0%

During fiscal year 2002, the Primary Health System defeased $5,320,000 of the 1998A bond issuance because IRS regulations do not permit tax-exempt debenture proceeds to be used to fund for-profit endeavors. These funds were used in the construction of an Ambulatory Surgery Center. The Primary Health System contributed to an escrow account funds generated from its operations sufficient to fund all principal and interest payments for approximately $5,320,000 of debentures until maturity. The Primary Health System was released from being the primary

NOTE G--LONG-TERM DEBT - Continued

obligor and cannot be held liable for the defeased obligation, of which approximately $4,670,000 remains outstanding at June 30, 2013.

The trust indentures and related documents underlying the bonds contain certain covenants and restrictions. For fiscal years 2013 and 2012, the Primary Health System failed to satisfy the debt service coverage ratio required by one of the bond insurers. As a result of the non-compliance, the Primary Health System will be required to engage a management consultant or obtain a waiver from the bond insurer.

The Primary Health System's scheduled principal and interest payments (estimated for variable rate debt based on rates at June 30, 2013) on bonds payable and other long-term debt (excluding capital leases) are as follows for the years ending June 30:

	Principal	*Interest*	*Total*
2014	$ 7,889,626	$ 6,271,219	$ 14,160,845
2015	10,605,736	5,868,787	16,474,523
2016	11,637,069	5,391,616	17,028,685
2017	11,723,446	4,945,072	16,668,518
2018	12,674,484	4,515,962	17,190,446
2019-2023	68,110,154	14,846,066	82,956,220
2024-2028	45,825,000	2,919,414	48,744,414
2029-2033	2,120,000	53,000	2,173,000
TOTAL	$ 170,585,515	$ 44,811,136	$ 215,396,651

Long-term debt activity for the Primary Health System for the years ended June 30, 2013 and 2012 consisted of the following:

	Balance at June 30, 2011	*Additions/ Amortizations*	*Reductions/ Accretions*	*Balance at June 30, 2012*	*Additions/ Amortizations*	*Reductions/ Accretions*	*Balance at June 30, 2013*
Bonds Payable							
Series 2004	$ 81,373,245	$ 151,904	$ 4,770,828	$ 76,754,321	$ 152,197	$ 4,950,828	$ 71,955,690
Series 2000	38,327,175	-	1,922,960	36,404,215	-	1,822,960	34,581,255
Series 1998A	18,984,847	14,769	140,000	18,859,616	14,769	545,000	18,329,385
Series 1997A	41,000,000	-	-	41,000,000	-	-	41,000,000
Premium paid on advance refunding	(981,127)	85,938	-	(895,189)	85,938	-	(809,251)
Total bonds payable	178,704,140	252,611	6,833,788	172,122,963	252,904	7,318,788	165,057,079

NOTE G--LONG-TERM DEBT - Continued

	Balance at June 30, 2011	*Additions/ Amortizations*	*Reductions/ Accretions*	*Balance at June 30, 2012*	*Additions/ Amortizations*	*Reductions/ Accretions*	*Balance at June 30, 2013*
Term Loan	6,902,514	-	619,620	6,282,894	-	652,379	5,630,515
Capital leases	343,807	6,616,296	125,436	6,834,667	-	93,463	6,741,204
Total long-term debt	$ 185,950,461	$ 6,868,907	$ 7,578,844	$ 185,240,524	$ 252,904	$ 8,064,630	$ 177,428,798

NOTE H--PENSION PLAN

The Primary Health System sponsors a single-employer, non-contributory defined benefit pension plan covering substantially all employees meeting certain age and service requirements. In addition to normal retirement benefits, the plan also provides for early retirement, delayed retirement, disability and death benefits. The Primary Health System funds the plan as contributions are approved by the Board of Trustees but not in amounts less than the minimum required contribution determined by the plan's consulting actuary. During the years ended June 30, 2013 and 2012, the Primary Health System made contributions of $11,165,100 and $10,367,970, respectively to the plan. The Primary Health System has the right to amend, in whole or in part, any or all of the provisions of the plan. The plan issues a publicly available financial report that includes a financial statement and required supplementary information for the plan. That report may be obtained by writing to Erlanger Health System, Attention: Human Resources Department, 975 East Third Street, Chattanooga, Tennessee 37403 or by calling 423-778-7000.

The annual pension cost and net pension obligation for the years ended June 30, 2013 and 2012 are as follows:

	Primary Health System	
	2013	*2012*
Annual required contribution	$ 11,165,100	$ 10,367,970
Interest on net pension obligation	791,073	798,800
Adjustment to annual required contribution	(899,189)	(901,802)
Annual pension cost	11,056,984	10,264,968
Contributions made	(11,165,100)	(10,367,970)
Change in net pension obligation	(108,116)	(103,002)
Net pension obligation at beginning of year	10,547,623	10,650,625
Net pension obligation at end of year	$ 10,439,507	$ 10,547,623

NOTE H--PENSION PLAN - Continued

The annual expected contribution for the years ended June 30, 2013 and 2012, was determined as part of the January 1, 2013 and 2012 actuarial valuations, respectively, using the projected unit credit cost method. The following actuarial assumptions were utilized:

	Primary Health System	
	2013	*2012*
Investment rate of return	7.5%	7.5%
Projected salary increases	4.0%	4.0%
Inflation	2.5%	2.5%
Increase in Social Security taxable wage base	3.5%	3.5%

Annual pension costs, contribution information and the net pension obligation for the last three fiscal years follows:

	Three-Year Trend Information		
Fiscal Year Ending	*Annual Pension Cost (APC)*	*Percentage of APC Contributed*	*Net Pension Obligation*
June 30, 2011	$ 8,831,554	100%	$ 10,650,625
June 30, 2012	10,264,968	101%	10,547,623
June 30, 2013	11,056,984	101%	10,439,507

The schedule of funding progress shown below presents multi-year trend information about whether the actuarial value of plan assets is increasing or decreasing over time relative to the actuarial accrued liability for benefits. The actuarial asset values are determined using prior year valuations with the addition of current year contributions and expected investment return on market value of assets based on an assumed rate of 7.5%, and deducting benefit payments and administrative expenses for the year. The actuarial value of assets was determined using techniques that smooth the effects of short-term volatility in the market value of investments using an average of cost and market value. The plan will reset the amortization base each year equal to the unfunded actuarial accrued liability to be amortized over a closed 20 year period (30 years in 2012 and prior periods) and using a level dollar amount as the amortization factor.

NOTE H–PENSION PLAN - Continued

Schedule of Funding Progress

Actuarial Valuation Date	*Actuarial Value of Assets*	*Actuarial Accrued Liability (AAL)*	*Total Unfunded AAL (UAAL)*	*Funded Ratio %*	*Annual Covered Payroll*	*UAAL as a Percentage of Covered Payroll*
1/1/11	$125,335,932	$ 150,926,741	$25,590,809	83.0%	$ 147,947,134	17.3%
1/1/12	124,520,999	160,704,688	36,183,689	77.5%	138,807,819	26.1%
1/1/13	121,700,323	170,980,311	49,279,988	71.2%	121,093,695	40.7%

Effective July 1, 2009, the Chattanooga-Hamilton County Hospital Authority Pension Plan was amended to be closed to new employees or rehires, and to further clarify the maximum years of service to be 30. The benefits of current employees will be protected and they will continue to participate in, and accrue services under, the Plan.

NOTE I--OTHER RETIREMENT PLANS

The Primary Health System maintains defined contribution plans under Section 403(b) and 401(a) of the IRC which provides for voluntary contributions by employees. The Plans are for the benefit of all employees 25 years of age or older with at least 12 months of employment.

The Primary Health System matches 50% of each participant's contribution up to 2% of the participant's earnings. Additionally, for eligible employees hired on after July 1, 2009 the Primary Health System will make profit sharing contributions equal to 3% of their earnings, regardless if the employee is making contributions. Employer contributions to the plan were $1,826,075 and $1,765,972 for the years ended June 30, 2013 and 2012, respectively.

NOTE J--POSTRETIREMENT BENEFITS OTHER THAN PENSIONS

The Primary Health System sponsors three defined benefit postretirement plans, other than pensions, for full-time employees who have reached retirement age, as defined. The respective plans provide medical, dental, prescription drug and life insurance benefits, along with a lump-sum cash payment for one-half of the hours in the participant's extended illness benefit bank at retirement. The postretirement health, dental and prescription drug plan is contributory and contains other cost-sharing features, such as deductibles and coinsurance. The life insurance plan and the extended illness bank are noncontributory.

The Primary Health System reports other postemployment benefits in accordance with the GASB Statement No. 45, *Accounting and Financial Reporting by Employers for Postemployment*

NOTE J--POSTRETIREMENT BENEFITS OTHER THAN PENSIONS - Continued

Benefits Other Than Pensions. This Statement addresses how state and local governments should account for and report their costs and obligations related to postemployment healthcare and other nonpension benefits. Collectively, these benefits are commonly referred to as other postemployment benefits, or OPEB. This Statement also establishes disclosure requirements for information about the plans in which an employer participates, the funding policy followed, the actuarial valuation process and assumptions, and, for certain employers, the extent to which the plan has been funded over time.

Beginning in 2018, under the Patient Protection and Affordable Care Act (the Act), a 40% excise tax will be imposed on the excess benefit provided to an employee or retiree in any month under any employer-sponsored health plan. In the case of a self-insured plan, the plan administrator must pay the tax. Because of the significant uncertainties regarding the excise tax on high cost plans, management of the Primary Health System is evaluating the impact of this Act but does not anticipate a material impact on the accrued liability at this time; however, actual results could differ from these estimates.

The following table shows the plan's funded status as of the actuarial valuation date as of June 30:

	2013	*2012*
Actuarial accrued liability	$ 30,500,450	$ 28,788,147
Market value of assets	-	-
Unfunded actuarial accrued liability	$ 30,500,450	$ 28,788,147

The following is a summary of the components of the annual OPEB cost recognized by the Primary Health System for the years ended June 30:

	2013	*2012*
Annual required contribution	$ 2,945,355	$ 2,659,068
Interest on the net obligation	228,288	163,912
Amortization of net obligation	(226,809)	(156,587)
OPEB cost recognized	$ 2,946,834	$ 2,666,393

NOTE J--POSTRETIREMENT BENEFITS OTHER THAN PENSIONS - Continued

Reconciliation of the net OPEB obligation for the fiscal years ended June 30:

	2013	*2012*
Net OPEB obligation beginning of the year	$ 5,707,193	$ 4,097,800
OPEB cost recognized	2,946,834	2,666,393
Actual contributions	(1,687,482)	(1,057,000)
Net OPEB obligation end of the year	$ 6,966,545	$ 5,707,193

Trend Information

Fiscal Year Ending	*Annual OPEB Cost*	*Percentage of Annual OPEB Cost Contributed*	*Net OPEB Obligation at the End of Year*
June 30, 2011	$ 2,508,668	32.7%	$ 4,097,800
June 30, 2012	2,666,393	39.6%	5,707,193
June 30, 2013	2,946,834	57.3%	6,966,545

Schedule of Funding Progress

Actuarial Valuation Date	*Actuarial Value of Assets*	*Actuarial Accrued Liability*	*Unfunded Actuarial Accrued Liability*	*Annual Covered Payroll*	*Unfunded Actuarial Accrued Liability as a Percent of Covered Payroll*	*Funded Ratio*
June 30, 2011	$ -	$ 24,966,769	$ 24,966,769	$147,947,134	16.9%	0%
June 30, 2012	-	28,788,147	28,788,147	138,807,819	20.7%	0%
June 30, 2013	-	30,500,450	30,500,450	155,727,806	19.6%	0%

The actuarial calculations reflect a long term perspective. Accordingly, the actuarial valuation involves estimates of the value of reported amounts and assumptions about the probability of events far into the future, and actuarially determined amounts are subject to continual revision as actual results are compared to past expectations and new estimates are made about the future.

The schedule of funding progress presents multi-year trend information about whether the actuarial value of plan assets is increasing or decreasing over time relative to the actuarial accrued liability. The calculations are based on the benefits currently provided under the terms of the plan as of the date of each valuation and on the sharing of cost between employer and plan members at that point.

NOTE J--POSTRETIREMENT BENEFITS OTHER THAN PENSIONS - Continued

The actuarial cost method utilized is the unit credit actuarial cost method. The 2013 postretirement benefit cost assumed an average weighted annual rate increase in per capita cost of covered health benefits of 7.4%, decreasing gradually to an ultimate rate of 4.8%. The 2012 postretirement benefit cost assumed an average weighted annual rate increase in per capita cost of covered health benefits of 9.6%, decreasing gradually to an ultimate rate of 4.6%.

The amortization method used is the level percent of payroll method over a thirty year amortization. Other assumptions include a 4% discount rate and assumed salary increases of 4.0% annually until age 65. The plan is currently open.

The Primary Health System also has a job injury program to provide benefits to workers injured in employment-related accidents. This program provides medical and indemnity benefits to employees injured in the course of employment for a period up to 24 months from the date of injury. The Primary Health System has recorded a projected liability of approximately $1,253,000 and $916,000 at June 30, 2013 and 2012, respectively. Such amounts are included as a part of other long-term liabilities in the combined statements of net position. The projected liability was discounted using a 4% rate of return at June 30, 2013 and 2012.

NOTE K--MEDICAL MALPRACTICE AND GENERAL LIABILITY CLAIMS

As of January 1, 1976, the Primary Health System adopted a self-insurance plan to provide for malpractice and general liability claims and expenses arising from services rendered subsequent to that date. In 1980, the Primary Health System's Self-Insurance Trust Agreement (the Agreement) was amended to include all coverages that a general public liability insurance policy would cover. In 1988, the Agreement was amended and restated to comply with amendments to the Tennessee Governmental Tort Liability Act and to formally include any claims and expenses related to acts of employees of the Primary Health System. The Primary Health System is funding actuarial estimated liabilities through a revocable trust fund with a bank included as a part of Assets Limited as to Use in the accompanying combined statements of net position. Such amounts in the trust can be withdrawn by the Primary Health System only to the extent there is an actuarially determined excess. The annual deposit to the self-insurance trust fund is determined by management based on known and threatened claims, consultation with legal counsel, and a report of an independent actuary. Losses against the Primary Health System are generally limited by the Tennessee Governmental Tort Liability Act to $300,000 for injury or death to any one person in any one occurrence or $700,000 in the aggregate. However, claims against healthcare practitioners are not subject to the foregoing limits applicable to the Primary Health System. Any such individuals employed by the Primary Health System, excluding employed physicians for which the Primary Health System has purchased insurance coverage, are covered by the Trust to the limits set forth therein.

NOTE K--MEDICAL MALPRACTICE AND GENERAL LIABILITY CLAIMS - Continued

In the opinion of management, the revocable trust fund assets are adequate at June 30, 2013, to cover potential liability and malpractice claims and expenses that may have been incurred to that date.

The Primary Health System provides for claims and expenses in the period in which the incidence related to such claims occur based on historical experience and consultation with legal counsel. It is the opinion of management that the reserve for estimated losses and loss adjustment expense (LAE) at June 30, 2013 and 2012, respectively, is adequate to cover potential liability and malpractice claims which may have been incurred but not reported (IBNR) to the Primary Health System. Such reserve for IBNR claims reflect a discount rate of 5.5% based on the Primary Health System's expected investment return during the payout period.

The following is a reconciliation of changes in the estimated losses and LAE that have been recognized in the combined financial statements for the years ended June 30, 2013 and 2012:

	Primary Health System	
	2013	*2012*
Reserve for losses and LAE at beginning of year	$ 5,462,500	$ 5,085,000
Provision for claims	178,439	1,203,977
Payments on claims	(655,939)	(826,477)
Reserve for losses and LAE at end of year	$ 4,985,000	$ 5,462,500

NOTE L--COMMITMENTS AND CONTINGENCIES

Litigation: The Primary Health System is subject to claims and suits which arise in the ordinary course of business. In the opinion of management, the ultimate resolution of such pending legal proceedings has been adequately provided for in its combined financial statements, and will not have a material effect on the Primary Health System's results of operations or financial position.

The prior Chief Executive Officer (CEO) resigned from Erlanger on December 31, 2011, after an interim CEO (the Executive Vice President) was established December 1, 2011. The interim CEO was replaced by the current CEO, hired on April 1, 2013. The Executive Vice President's employment at Erlanger ended when her leave expired in June, 2013. She has filed a wrongful termination lawsuit against Erlanger for $25 million, which Erlanger, in conjunction with its Directors & Officers insurance carrier, is currently defending. The ultimate outcome of this lawsuit is uncertain.

NOTE L--COMMITMENTS AND CONTINGENCIES - Continued

Management Agreement: During 2012, the Primary Health System entered into a Management Agreement with a third party related to Plaza. The Agreement is for an initial term of five years (subject to one three-year renewal). The Agreement requires annual payments of $180,000 and reimbursement of defined expenses.

Health Care Reform: In March 2010, Congress adopted comprehensive healthcare insurance legislation, Patient Care Protection and Affordable Care Act and Health Care and Education Reconciliation Act. The legislation, among other matters, is designated to expand access to coverage to substantively all citizens by 2019 through a combination of public program expansion and private industry health insurance. Changes to existing TennCare and Medicaid coverage and payments are also expected to occur as a result of this legislation. Implementing regulations are generally required for these legislative acts, which are to be adopted over a period of years and, accordingly, the specific impact of any future regulations is not determinable.

NOTE M--LEASES

Capital: As discussed in Note E, during 2012, the Primary Health System entered into a sale/leaseback arrangement, under which certain leases of office space meet the criteria as capital leases. Interest on these leases has been estimated at 7% per annum.

During 2011, the Primary Health System acquired a parcel of land from the Industrial Development Board of the City of Chattanooga, Tennessee for a nominal amount. The Primary Health System also entered into a project development agreement with a developer to facilitate final design, financing and construction of a medical office building for the benefit of Volkswagen Group of America Chattanooga Operations, LLC (Volkswagen) on this land. The Primary Health System has entered into a forty year ground lease, with the option of two ten year renewal terms, of the parcel to the developer. Additionally, in 2012, the Primary Health System has entered into a twenty year lease with the developer for certain space in the medical office building for a wellness center and other operations under a capital lease agreement.

The following is an analysis of the property under capital leases by major classes at June 30:

	Primary Health System	
	2013	***2012***
Buildings	$ 6,601,812	$ 6,597,396
Equipment	494,905	323,765
	7,096,717	6,921,161
Less: accumulated amortization	(593,019)	(159,961)
	$ 6,503,698	$ 6,761,200

NOTE M--LEASES - Continued

The following is a schedule of future minimum lease payments under capital leases at June 30, 2013:

Year Ending June 30,	
2014	$ 845,820
2015	702,264
2016	715,938
2017	729,998
2018	744,472
2019-2023	3,827,865
2024-2028	3,693,101
2029-2033	2,760,506
Total minimum lease payments	14,019,964
Less: amount representing interest	(7,278,760)
Present value of minimum lease payments (including current portion of $140,579)	$ 6,741,204

Operating: The Primary Health System rents office space and office equipment under non-cancelable operating leases through 2033, containing various lease terms. The leases have other various provisions, including sharing of certain executory costs. Rent expense under operating leases was approximately $7,450,000 and $6,130,000 in 2013 and 2012, respectively. Future minimum lease commitments at June 30, 2013 for all non-cancelable leases with terms in excess of one year are as follows:

Year Ending June 30,	
2014	$ 6,393,113
2015	4,151,854
2016	2,644,970
2017	2,603,297
2018	2,305,727
Thereafter	19,292,193
	$ 37,391,154

Rental Revenues: The Primary Health System leases office space to physicians and others under various lease agreements with terms in excess of one year. Rental revenue recognized for the

NOTE M--LEASES - Continued

years ended June 30, 2013 and 2012 totaled approximately $4,261,000 and $6,043,000, respectively. The following is a schedule of future minimum lease payments to be received for the years ending June 30:

Year Ending June 30,	
2014	$ 1,214,205
2015	874,495
2016	198,910
2017	122,057
2018	7,116
Thereafter	-
	$ 2,416,783

NOTE N--DERIVATIVE FINANCIAL INSTRUMENTS

Simultaneous with the issuance of the $85,000,000 Series 2004 bonds discussed in Note G, the Primary Health System entered into interest rate swap agreements. In an effort to take advantage of the differences between taxable and tax-exempt debt, and manage exposure to interest rate risks associated with various debt instruments, the Primary Health System was a party to three distinct interest rate swap agreements with Lehman Brothers Special Financing, Inc. (Lehman).

In 2012, the Primary Health System entered into a novation agreement whereby Lehman transferred its rights and obligations under the interest rate swaps to another party. The terms of the interest rate swap agreements did not substantially change and no gain or loss was recognized on this transfer.

With respect to the Series 2004 bonds, the Primary Health System executed a swap where the Primary Health System receives a variable rate equal to 67% of the one-month LIBOR-BBA rate and pays a fixed rate of 3% on a notional amount of $7,150,000 at June 30, 2013. Unless terminated at an earlier date (at the Primary Health System's option), this agreement terminates on October 1, 2013.

With respect to the 1997A Series bonds, the Primary Health System executed a swap agreement whereby the Primary Health System receives a variable rate equal to the one-month LIBOR-BBA rate and pays a fixed rate equal to 5.087% on a notional amount of $41,000,000. Unless terminated at an earlier date (at the Primary Health System's option), this agreement terminates on October 1, 2027.

NOTE N--DERIVATIVE FINANCIAL INSTRUMENTS - Continued

With respect to the 1998A Series bonds, the Primary Health System executed a swap agreement whereby the Primary Health System receives a fixed rate of 3.932% and pays a variable rate equal to the Securities Industry and Financial Markets Association (SIFMA) Municipal Swap Index on a notional amount of $16,305,000. Unless terminated at an earlier date (at the Primary Health System's option), this agreement terminates on October 1, 2027.

Although these swap instruments are intended to manage exposure to interest rate risks associated with the various debt instruments referred to above, none of these swap agreements have been determined to be effective hedges. Accordingly, the interest rate swaps are reflected in the accompanying combined statements of net position at their aggregate fair value (a net liability of $4,856,429 and $7,112,464 at June 30, 2013 and 2012, respectively) and the changes in the value of the swaps are reflected as a component of non-operating revenues in the combined statements of revenue, expenses and changes in net position.

Management has considered the effects of any credit value adjustment and while management believes the estimated fair value of the interest rate swap agreements is reasonable, the estimate is subject to change in the near term.

NOTE O--FAIR VALUE MEASUREMENT

FASB ASC 820, *Fair Value Measurements and Disclosures,* establishes a three-level valuation hierarchy for disclosure of fair value measurements. The valuation hierarchy is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date. The three levels are defined as follows:

- Level 1 - Quoted market prices in active markets for identical assets or liabilities.
- Level 2 - Observable market-based inputs or unobservable inputs that are corroborated by market data.
- Level 3 - Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes values determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Primary Health System's own assumptions.

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Primary Health System's assessment of the

NOTE O--FAIR VALUE MEASUREMENT - Continued

significance of a particular input to the fair value measurement in its entirety requires judgment and considers factors specific to the asset or liability.

The following tables present assets and liabilities reported at fair value as of June 30, 2013 and 2012 and their respective classification under the FASB ASC 820 valuation hierarchy:

	Carrying Value	*Level 1*	*Level 2*	*Level 3*
As of June 30, 2013				
Assets Measured at Fair Value on a Recurring Basis				
Investment in government and agency bonds, including municipal bonds, mutual funds and others	$ 111,569,814	$ 111,569,814	$ -	$ -
Investments in corporate bonds and commercial paper	4,348,798	4,348,798	-	-
Short-term investments and cash equivalents	29,929,179	29,929,179	-	-
Liabilities Measured at Fair Value on a Recurring Basis				
Interest rate swap agreements	(4,856,429)	-	-	(4,856,429)
As of June 30, 2012				
Assets Measured at Fair Value on a Recurring Basis				
Investment in government and agency bonds, including municipal bonds, mutual funds and others	$ 119,596,675	$ 119,596,675	$ -	$ -
Investments in corporate bonds and commercial paper	940,586	940,586	-	-
Short-term investments and cash equivalents	32,688,220	32,688,220	-	-
Liabilities Measured at Fair Value on a Recurring Basis				
Interest rate swap agreements	(7,112,464)	-	-	(7,112,464)

A certain portion of the inputs used to value the Primary Health System interest rate swap agreements are unobservable inputs available to a market participant. As a result, the Primary Health System has determined that the interest rate swap valuations are classified in Level 3 of the fair value hierarchy.

The following table provides a summary of changes in the fair value of the Primary Health System's interest rate swap agreements liabilities during the fiscal year ended June 30:

NOTE O--FAIR VALUE MEASUREMENT - Continued

	2013	2012
Beginning of year	$ (7,112,464)	$ (6,032,288)
Change in mark-to-market of interest rate swaps	2,256,035	(1,080,176)
End of Year	$ (4,856,429)	$ (7,112,464)

NOTE P--MANAGEMENT AGREEMENT

On April 13, 2011, the Primary Health System's Board of Trustees approved a resolution authorizing a management agreement (the Agreement) between the Primary Health System, Hutcheson Medical Center, Inc. and affiliates (collectively, Hutcheson) and the Hospital Authority of Walker, Dade and Catoosa Counties in Georgia (the Hospital Authority).

Under the terms of the Agreement, the Primary Health System will propose general operating policies and directives for Hutcheson; be responsible for the day-to-day management of Hutcheson and provide oversight of ancillary aspects of Hutcheson, such as physician practices, education, research, and clinical services. The Agreement's initial term is through March 31, 2021 and the Primary Health System has the option to extend the agreement for two additional five year terms. The Primary Health System may terminate the Agreement, without cause, upon written notice at any point subsequent to May 25, 2013. Upon such termination, Hutcheson is obligated to make a Termination Payment to the Primary Health System consisting of all expenses then owed by Hutcheson and any outstanding advances under a Line of Credit Agreement, discussed below. Hutcheson may also terminate the agreement without cause at any point subsequent to May 25, 2013 by paying the Termination Payment, as well as the lesser of a) $1,000,000 per year for each year the Agreement has been in place, or b) $1,000,000 less any management fees paid in each Agreement year.

In addition to the Agreement, the Primary Health System agreed to extend a Line of Credit (the Line) to the Hospital Authority. The maximum amount available under the Line is $20,000,000 at June 30, 2012. During the year ended June 30, 2013 The Agreement was amended to increase the maximum amount to $20,550,000. At June 30, 2013 and 2012, the draws on the Line totaled $20,550,000 and $12,500,000, respectively.

The Line calls for interest only payments each month on the outstanding balance, based on the London InterBank Offered Rate plus 4% or a rate of 5%, whichever is greater. However, any unpaid interest through March 31, 2013 is deferred and paid over a twelve-month period commencing on that date. All outstanding draws are due at the maturity date, which is consistent with the Agreement termination dates, discussed above.

NOTE P--MANAGEMENT AGREEMENT - Continued

The Line is secured by a Security Agreement on the primary Hutcheson medical campus. Further, the Counties of Walker and Catoosa, Georgia (collectively, the Counties) have provided additional security in the form of guarantees under an Intergovernmental Agreement. Under the Intergovernmental Agreement, the Counties have each agreed to a maximum liability of $10,000,000 to secure the line. The form of such guarantee is at the option of the Counties and would become enforceable upon a notice of default delivered by the Primary Health System. The form of the guarantee selected by the Counties can include a) a payment of 50% by each County of the amounts owing under the Line, b) payments as they become due up to the respective $10,000,000 limits or c) after non-Judicial foreclosure under the Security Agreement, each County could elect to pay 50% of any deficiency between the amount outstanding under the Line and the then fair market value. Both Counties have agreed to levy annual property taxes, if needed to honor these guarantees.

In June 2013, the Agreement was modified to allow Hutcheson to issue requests for proposals for the lease or sale of Hutcheson properties without creating a breach of the Agreement. As part of the Agreement, Hutcheson has committed to obtain alternative financing and repay the line of credit upon the earlier of the replacement financing being obtained by Hutcheson, or June 1, 2014. As such the line of credit is classified as a current asset as of June 30, 2013.

NOTE Q--COMBINED, CONDENSED FINANCIAL INFORMATION

The following is combined, condensed, financial information related to those aggregate discretely presented component units as of and for the years ended June 30, 2013 and 2012:

	ContinuCare HealthServices, Inc.	*Cyberknife of Chattanooga, LLC*
As of June 30, 2013		
Due from other governments	$ 248,239	$ 129,000
Other current assets	8,865,703	490,008
Total Current Assets	9,113,942	619,008
Net property, plant and equipment	5,174,936	4,468,880
Other assets	2,383,609	75,309
Total Assets	$ 16,672,487	$ 5,163,197

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CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Notes to Combined Financial Statements - Continued

Years Ended June 30, 2013 and 2012

NOTE Q--COMBINED, CONDENSED FINANCIAL INFORMATION - Continued

	ContinuCare HealthServices, Inc.	*Cyberknife of Chattanooga, LLC*
Due to other governments	$ 408,032	$ 120,000
Other current liabilities	3,035,595	788,584
Total Current Liabilities	3,443,627	908,584
Long-term debt and capital lease obligations	29,292	3,416,667
Total Liabilities	3,472,919	4,325,251
Net position		
Unrestricted	8,110,622	210,424
Invested in capital assets, net of related debt	5,088,946	627,522
Restricted expendable	-	-
Total Net Position	13,199,568	837,946
Total Liabilities and Net Position	$ 16,672,487	$ 5,163,197
Year Ended June 30, 2013		
Net patient and operating revenue	$ 26,026,863	$ 1,560,900
Operating expenses:		
Salaries, wages and benefits	13,395,486	211,954
Supplies and other expenses	9,715,354	484,205
Purchased services	2,914,446	66,602
Insurance and taxes	267,877	27,459
Depreciation	517,483	527,752
Total Operating Expenses	26,810,646	1,317,972
Operating Income	(783,783)	242,928
Nonoperating revenue (expenses)	497,259	(194,623)
Change in Net Position	(286,524)	48,305
Net Position at Beginning of Period	13,486,092	789,641
Net Position at End of Period	$ 13,199,568	$ 837,946

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Notes to Combined Financial Statements - Continued

Years Ended June 30, 2013 and 2012

NOTE Q--COMBINED, CONDENSED FINANCIAL INFORMATION - Continued

	ContinuCare HealthServices, Inc.	*Cyberknife of Chattanooga, LLC*
As of June 30, 2012		
Due from other governments	$ 234,872	$ 266,600
Other current assets	7,984,697	270,923
Total Current Assets	8,219,569	537,523
Net property, plant and equipment	4,916,085	4,967,921
Other assets	3,664,684	75,309
Total Assets	$ 16,800,338	$ 5,580,753
Due to other governments	$ 779,987	$ 125,842
Other current liabilities	2,534,259	748,603
Total Current Liabilities	3,314,246	874,445
Long-term debt and capital lease obligations	-	3,916,667
Total Liabilities	3,314,246	4,791,112
Net position		
Unrestricted	8,570,007	163,078
Invested in capital assets, net of related debt	4,916,085	626,563
Total Net Position	13,486,092	789,641
Total Liabilities and Net Position	$ 16,800,338	$ 5,580,753
Year Ended June 30, 2012		
Net patient and operating revenue	$ 26,434,498	$ 1,595,300
Operating expenses:		
Salaries, wages and benefits	12,898,683	202,693
Supplies and other expenses	10,146,545	307,497
Purchased services	2,609,813	178,764
Insurance and taxes	259,226	107,290
Depreciation	327,769	521,106
Total Operating Expenses	26,242,036	1,317,350
Operating Income	192,462	277,950

NOTE Q--COMBINED, CONDENSED FINANCIAL INFORMATION - Continued

	ContinuCare HealthServices, Inc.	*Cyberknife of Chattanooga, LLC*
Nonoperating revenue (expenses)	(50,099)	(217,734)
Change in Net Position	142,363	60,216
Net Position at Beginning of Period	13,343,729	729,425
Net Position at End of Period	$ 13,486,092	$ 789,641

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

October 1, 2014

Joseph M. Winick, Sr. Vice President
Planning & Business Development
Erlanger Health System
975 East 3rd Street
Chattanooga, TN 37403

RE: Certificate of Need Application -- Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Medical Center - CN1409-038

Dear Mr. Winick:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need for the addition of a 3.0 T Magnetic Resonance Imaging (MRI) scanner at Erlanger Medical Center, 975 East 3rd Street, Chattanooga (Hamilton County), Tennessee. Project cost is $4,597,711.00.

Please be advised that your application is now considered to be complete by this office. Your application is being forwarded to the Tennessee Department of Health and/or its representative for review.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on October 1, 2014. The first sixty (60) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the sixty (60) day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on December 17, 2014.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill/MF

Melanie M. Hill
Executive Director

MMH:mab

cc: Trent Sansing, CON Director, Division of Health Statistics

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Trent Sansing, CON Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

FROM: Melanie M. Hill MMH/MF
Executive Director

DATE: October 1, 2014

RE: Certificate of Need Application
Chattanooga-Hamilton County Hospital Authority d/b/a
Erlanger Medical Center - CN1409-038

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on October 1, 2014 and end on December 1, 2014.

Should there be any questions regarding this application or the review cycle, please contact this office.

MMH:mab

Enclosure

cc: Joseph M. Winick, Sr. Vice President, Planning & Business Development

LETTER OF INTENT
TENNESSEE HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Chattanooga Times Free Press, which is a newspaper of general circulation in Hamilton County, Tennessee, on or before September 10, 2014, for one day.

This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. §68-11-1601 *et. seq.*, and the Rules of the Health Services & Development Agency, that Erlanger Medical Center, owned by the Chattanooga-Hamilton County Hospital Authority D/B/A Erlanger Health System, with an ownership type of governmental, and to be managed by itself, intends to file an application for a Certificate of Need for a Magnetic Resonance Imaging (Tesla 3.0) Scanner. No other health care services will be initiated or discontinued.

The facility and equipment will be located in Erlanger Medical Center, at 975 East 3rd Street, Chattanooga, Hamilton County, Tennessee 37403. The total project cost is estimated to be $ 4,597,711.00.

The anticipated date of filing the application is September 15, 2014.

The contact person for this project is Joseph M. Winick, Sr. Vice President, Erlanger Health System, 975 East 3rd Street, Chattanooga, Tennessee 37403, and by phone at (423) 778-7274.

Joseph M. Winick	September 5, 2014	Joseph.Winick@erlanger.org
	Date:	E-Mail:

The Letter Of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services & Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

The published Letter Of Intent must contain the following statement pursuant to T.C.A. §68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

ORIGINAL-SUPPLEMENTAL-2

Erlanger Health System
CN1409-038

SUPPLEMENTAL #2
September 30, 2014
4:05 pm

erlanger

September 29, 2014

Mr. Phillip M. Earhart
HSD Examiner
State of Tennessee
Health Services & Development Agency
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, TN 37243

RE: 3T MRI CON Application
Chattanooga- Hamilton County Hospital Authority d//b/a Erlanger Medical Center
Response to Request for Supplemental Information

Dear Mr. Earhart;

Enclosed is the information you requested in your letter of September 29, 2014. We hope that you find the information satisfactory such that are application can be deemed complete. However, should you have additional questions or need further clarification of the information provided we will be please to provide this information.

We look forward to working with you and the HSDA in the review of our application.

Sincerely,

Joseph M. Winick, FACHE
Senior Vice President
Planning & Business Development

SUPPLEMENTAL #2
September 30, 2014
4:05 pm

SUPPLEMENTAL INFORMATION (No. 2)

Chattanooga-Hamilton County Hospital Authority

D / B / A

Erlanger Medical Center

Application For

Magnetic Resonance Imaging (Tesla 3.0)

On The Main Campus Of
Erlanger Health System

Application Number CN1409-038

September 29, 2014

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

SUPPLEMENTAL #2

September 30, 2014
4:05 pm

Supplemental Responses To Questions Of The Tennessee Health Services & Development Agency

1.) **Section B, Project Description, Item II.E 1.b & 1.3.**

It is noted the applicant will purchase the 3T MRI. However, please itemize the $3,013,702 cost for fixed equipment in the Project Costs Chart. This amount is not found in the Equipment Quote found in Attachment A-59.

Response

The detail is below.

MRI Unit – 3.0 Tesla	$ 2,289,114
Service Agreement (Years 1-5)	724,588
Total	$ 3,013,702

2.) **Section C, Economic Feasibility, Item 1 (Historical & Projected Data Charts).**

The historical chart indicates the applicant has operated at a loss of approximately $12 million in 2011, $26 million in 2012, and $24 million in 2013. A Projected Data Chart for Erlanger Medical Center for Year One and Year Two of the proposed project was requested in Supplemental One, but not provided. The applicant did provide a copy of the FY2014 audit report which shows positive income from operations of $17,917,993. Please clarify if the applicant intended to submit the audit in lieu of the request for a Projected Data Chart for Erlanger Medical Center. If so, please provide an estimate of the financial performance for Erlanger Medical Center in Year Two (2015) of the proposed project.

Response

Our apology, we intended to provide the requested *Projected Data Chart*, as requested. The *Projected Data Chart* is attached to this supplemental information.

Further, We understood that you were looking for information to demonstrate economic feasibility as you

referenced prior year shortfalls in your question. For this reason, we provided audited financial statements to demonstrate that *Erlanger Medical Center* has the resources to fund and operate the proposed project. For FY 15, we are projecting positive income from operations of $18.4 million.

3.) Section C, Economic Feasibility, Question 5.

The average gross charge, average deduction and average net charge are noted. However, please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please verify the following:

Year One
Year One Gross Charge: $3,614.00
Year One Deduction from Revenue: $2,952.00
Average Net Charge: $662.00

Year Two
Year Two Gross Charge: $3,774.00
Year Two Deduction from Revenue: $3,107.00
Average Net Charge: $667.00.

Response

The amounts shown above for average gross charge, average deduction from revenue and average net revenue are correct based upon the *Projected Data Chart*. Some of our calculations in the first supplement were in error.

4.) Section C, Economic Feasibility, Question 6.B.

The comparison of the proposed MRI Gross Charges per Procedure/Treatment by quartiles using the following table is noted. However, please compare the average gross charge of $3,614.00 in Year One to the charges below.

Gross Charges per Procedure/Treatment
By Quartiles
YEAR = 2013

Equipment Type	1st Quartile	Median	3rd Quartile
MRI	$1,570.39	$2,175.15	$3,498.94
Source: Medical Equipment Registry – 8/11/2014			

Response

The average gross charge of $ 3,614.00 for this project would be in the 3rd quartile in comparison to the table in the provided.

5.) Section C, Economic Feasibility, Item 9.

As requested in Supplemental One, please indicate how medically indigent patients will be served by the project.

Response

As a safety net provider, *Erlanger Medical Center* serves all patients regardless of their ability to pay. Medically indigent patients have access to all services provided by *Erlanger*. If a medically indigent patient is referred for services, our financial counselors will meet with the patient the assess ability to pay. *Erlanger* will also make a determination as to whether or not the individual would qualify for reimbursement under the *Affordable Care Act*. In the event a determination is made that the patient is medically indigent, the patient will be scheduled on a routine basis to receive the service for which a physician's order has been received. No patient is denied service based on their inability to pay.

6.) Section C, Contribution To Orderly Development, Item 3 (Staffing).

The table of the current and proposed staffing patterns in the proposed service area is noted. However, please provide the reference for the area wide wages, i.e.-Tennessee Department of Labor and Workforce Development and/or other documented sources.

Response

The area wide wage comparisons were obtained from *Towers Watson*, a human resources consultancy firm.

SUPPLEMENTAL #2
September 30, 2014
4:05 pm

A F F I D A V I T

STATE OF TENNESSEE |
|
COUNTY OF HAMILTON |

NAME OF FACILITY Erlanger Medical Center

I, Joseph M. Winick, after first being duly sworn, State under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

SIGNATURE

SWORN to and subscribed before me this 29 of September (Month), 2014 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

SHELIA HALL
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

Shelia Hall
NOTARY PUBLIC

My commission expires June 9 (Month / Day), 2018.

SUPPLEMENTAL #2
September 30, 2014
4:05 pm

TABLE OF ATTACHMENTS

SUPPLEMENTAL #2

September 30, 2014

4:05 pm

** NOTE - The attachments are paginated and the page number begins with "A". The page number appears in the upper right hand corner of the page.

SUPPLEMENTAL #2

September 30, 2014
4:05 pm

ATTACHMENTS

PROJECTED DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in ___July___ (Month).

		Year 1	Year 2
A.	Utilization Data	2,350	2,975
	(Specify Unit Of Measure) _MRI Procedures_		
B.	Revenue From Services To Patients		
	1. Inpatient Services		
	2. Outpatient Services	8,492,065	11,227,918
	3. Emergency Services		
	4. Other Operating Revenue		
	(Specify) _____		
	Gross Operating Revenue	8,492,065	11,227,918
C.	Deductions From Operating Revenue		
	1. Contractual Adjustments	6,569,444	8,758,777
	2. Provision For Charity Care	115,542	152,766
	3. Provision For Bad Debt	251,282	332,236
	Total Deductions	6,936,268	9,243,779
	NET OPERATING REVENUE	1,555,797	1,984,139
D.	Operating Expenses		
	1. Salaries And Wages	240,435	250,774
	2. Physician's Salaries And Wages		
	3. Supplies	19,580	25,586
	4. Taxes		
	5. Depreciation	431,301	431,301
	6. Rent		
	7. Interest - Other Than Capital		
	8. Management Fees:		
	a. Fees To Affiliates		
	b. Fees To Non-Affiliates		
	9. Other Expenses	365,590	413,329
	(Specify) _Contrast Agent, Svc. Contract, etc._		
	Total Operating Expenses	1,056,906	1,120,990
E.	Other Revenue (Expenses) – Net		
	(Specify) _____		
	NET OPERATING INCOME (LOSS)	498,891	863,149
F.	Capital Expenditures		
	1. Retirement Of Principal		
	2. Interest		
	Total Capital Expenditures		
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	498,891	863,149

COPY-
SUPPLEMENTAL-1

Erlanger Medical center
CN1409-038

SUPPLEMENTAL- 1

erlanger

September 26, 2014
11:40am

September 24, 2014

Mr. Phillip M. Earhart
HSD Examiner
State of Tennessee
Health Services & Development Agency
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, TN 37243

RE: 3T MRI CON Application
Chattanooga- Hamilton County Hospital Authority d//b/a Erlanger Medical Center
Response to Request for Supplemental Information

Dear Mr. Earhart;

Enclosed is the information you requested in your letter of September 24, 2014. We hope that you find the information satisfactory such that are application can be deemed complete. However, should you have additional questions or need further clarification of the information provided, we will be pleased to provide this information.

We look forward to working with you and the HSDA in the review of our application.

Sincerely,

Joseph M. Winick

Joseph M. Winick, FACHE
Senior Vice President
Planning & Business Development

SUPPLEMENTAL- 1

September 26, 2014
11:40am

SUPPLEMENTAL INFORMATION

Chattanooga-Hamilton County Hospital Authority

D / B / A

Erlanger Medical Center

Application For

Magnetic Resonance Imaging (Tesla 3.0)

On The Main Campus Of
Erlanger Health System

Application Number CN1409-038

September 26, 2014

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

SUPPLEMENTAL- 1

September 26, 2014
11:40am

Supplemental Responses To Questions Of The Tennessee Health Services & Development Agency

1.) Section A, Applicant Profile, Item 2.

Please note the association of the contact person with the owner.

Response

Joseph Winick is a corporate officer and Senior Vice President of *Chattanooga-Hamilton County Hospital Authority* D/B/A *Erlanger Health System*, responsible for Strategic Planning & Business Development.

2.) Section A, Applicant Profile, Item 5 (Management/Operating Entity).

Please provide a copy of the management/operating agreement. If the applicant will be managing itself, please provide a replacement noting N/A as the response.

Response

Applicant will manage itself, a replacement page is attached to this supplemental information.

3.) Section A, Applicant Profile, Item 6.

The Agency will need a deed, a purchase agreement, lease agreement, option to lease or other legal document which demonstrates the applicant has a legitimate legal interest in the property on which to locate the project.

Response

A copy of the Quit Claim Deed pertaining to *Erlanger Medical Center's* main campus is attached to this supplemental information.

4.) Section A, Applicant Profile, Item 13.

The applicants contract with United Health Plan is noted. However, please clarify why the applicant does not have a contract with United Healthcare Community Plan for TennCare enrollee's over the age of 21.

New TennCare Managed Care contracts with the Bureau of TennCare will take effect January 1, 2015, with full statewide implementation for AmeriGroup, BlueCare Tenessee and united Healthcare. Please indicate the stages of contract discussions with each MCO for these new contracts.

Response

Concerning the question pertaining to *United Healthcare Community Plan* for TennCare enrollee's over the age of 21, negotiations were not successful because agreement could not be reached regarding reasonable rates for adults. However, these patients still have access to Erlanger medical Center even in the absence of an agreement.

We have contracts with *AmeriGroup* and *BlueCare Tennessee*, these agreements are being updated. Further, we are currently in negotiation with *United Healthcare Community Plan* pertaining to a full service contract.

5.) Section B, Item 2 (Project Description).

Please provide a brief description of the following: proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing. Please list each area and provide a brief response underneath.

Response

Proposed Services & Equipment

Erlanger Medical Center seeks to acquire a 3.0 Tesla MRI Unit.

Ownership Structure

The *Chattanooga-Hamilton County Hospital Authority* is a governmental unit of the *State of Tennessee*, created

by a private act of the *Tennessee General Assembly* in 1976. The hospital authority does business under the trade names of *Erlanger Health System* and *Erlanger Medical Center*, among others. As a governmental unit, there are no "owners" per se, other than the people and general public of the *State of Tennessee*.

Service Area

The service area for this project is defined as Hamilton County, Tennessee (Primary), and the 10 counties in Tennessee which surround Hamilton County which comprise the Secondary Service Area … Bradley, Marion, Grundy, Sequatchie, Bledsoe, Rhea, Meigs, McMinn and Polk.

Need

Erlanger Medical Center has a need to acquire a 3.0 Tesla MRI unit because current utilization of our 3 other MRI units operated at 34% higher than optimal capacity of 2,880 procedures (i.e.-80% threshold). We have had to add a 3rd shift in the MRI dept. to accmmodate our increased demand. Further, 3.0 Tesla MRI technology is becoming the standard of care for MR imaging.

Existing Resources

There are currently 3 other 3.0 Tesla units (*Memorial Hospital, Memorial Ooltewah Imaging Center and Chattanooga O/P Center*). Also, *Parkridge Medical Center* currently has a CON application pending for a 3.0 Tesla unit.

Project Cost

The estimated project cost (per *HSDA* rules) is $ 4,597,711.

Funding

The funding for this project will be provided from operations of *Erlanger Medical Center*.

Financial Feasibility

This project is financially feasible as demonstrated by the *Projected Data Chart*, which shows a positive financial result of $ 498,891 in year 1 and $ 863,149 in year 2.

Staffing

Staffing for the 3.0 Tesla MRI unit will be 1.5 additional Radiologic Technologists.

6.) **Section B, Project Description, Item 2C.**

The applicant states on July 2, 2014, a 3rd shift (night shift) was implemented in the MRI department. Please clarify the hours of the night shift. In July and August, 2014, how many MRI scans were conducted during the following shifts ?

7am - 3 pm _____
3pm - 11pm _____
11pm - 7 am _____

The applicant states in 2013, 759 patients that required 3.0 Tesla Imaging were referred for services. Please indicate where these patients were referred.

Response

The number of MRI scans for July and August, 2014, by shift are as follows:

7 a.m. - 3 p.m.	865
3 p.m. - 11 p.m.	798
11 p.m. - 7 a.m.	240

The 3.0 Tesla MRI patients were referred to *Chattanooga Outpatient Center* and *Memorial Hospital*.

7.) **Section B, Project Description, Item 2E - 1.b and 1.3.**

The hours of operation for the existing 3 MRIs and the proposed 3T MRI is noted. However, please clarify why the 3T MRI will not be open from 7 am-8 am and 8 pm-11 pm Mon-Sat, and not open on Sundays. During those times and from 11 pm to 7 am, where will patients who need 3T MRI services be referred ?

It is noted the applicant will purchase the 3T MRI. Howèver, please itemize the $3,013,702 cost for fixed equipment in the Project Costs Chart. This amount is not found in the Equipment Quote found in Attachment A-59.

The applicant indicates the clinical applications for proposed 3.0 Tesla MRI include: Neurological Imaging, Orthopedic Imaging, and Pediatric Imaging. Please discuss the clinical advantages of images acquired by a 3.0 Tesla MRI vs. a 1.5 Tesla MRI in each of the above specialty areas.

Response

The hours of operation are for start-up of this specific service and will be adjusted as needed. Any patient needing a specific 3.0 Tesla MRI scan during the night shift can be accommodated with on-call staffing as needed.

Pertaining to the clinical advantages of this technology, Steven Quafordt, M.D., one of the Radiologists on the medical staff for *Erlanger Medical Center*, has provided information indicating that 3.0 Tesla imaging has significantly enhanced sensitivity for detecting a wide range of lesions, faster acquisition time to reduce motion artifact, as well as improved image clarity for small pathology such as aneurysms and joint disease. The 3.0 Tesla imaging also eliminates the need for an endo-rectal coil for prostate imaging, thereby increasing patient satisfaction and reducing risk associated with coil insertion. Pediatric patients under anesthesia will have a decrease in scan time reducing the amount of time spent under anesthesia, thus reducing motion artifact and improved image quality. MRA (i.e.-MR Angiography) studies have a 20% improvement in image clarity with a 3.0 Tesla MRI unit. Also, the addition of image diffusion is made possible by the 3.0 Tesla MRI unit.

8.) Section B, Item 2 (Floor Plan).

The floor plan is noted. However, please note the location of the proposed 3T MRI on the floor plan and resubmit.

Response

An updated floor showing the location of the 3.0 Tesla MRI unit is attached to this supplemental information.

9.) Section C, Item 1 (Specific Criteria, Magnetic Resonance Imaging(1.a)).

The applicant states a 3.0 Tesla MRI is becoming the standard of care in imaging in Orthopedics, Neurology, and Pediatrics. Please provide documentation to verify that statement.

The proposed 3T MRI projected volume includes reallocation from the other three MRI's due to over capacity. The reallocation ranges from 665 in Year 1 to 950 in Year 2. Please clarify if the allocation cases would be the most clinically appropriate for a 3T MRI.

After the relocation from the 3 existing MRIs to the proposed 3T MRI, please complete the following table:

Projected Volume

	Year One	Year Two	Year Three
MRI#1			
MRI #2			
MRI #3			
Proposed 3T			
Total			

Response

Steven Quafordt, M.D., one of the Radiologists on the medical staff for *Erlanger Medical Center*, has provided information indicating that 3.0 Tesla imaging has significantly enhanced sensitivity for detecting a wide range of lesions, faster acquisition time to reduce motion artifact, as well as improved image clarity for small pathology such as aneurysms and joint disease. The 3.0 Tesla imaging also eliminates the need for an endo-rectal coil for prostate imaging, thereby increasing patient satisfaction and reducing risk associated with coil insertion. Pediatric patients under anesthesia will have a decrease in scan time reducing the amount of time spent under anesthesia, thus reducing motion artifact and improved image quality. MRA (i.e.-MR Angiography) studies have a 20% improvement in image clarity with a 3.0 Tesla MRI unit. Also, the addition of image diffusion is made possible by the 3.0 Tesla MRI unit.

Concerning clinical appropriateness of re-allocating some patients to the 3.0 Tesla unit from a 1.5 Tesla unit, applicant acknowledges that this will occur; however, there may also be other clinical considerations involved with performing MRI scans on inpatients during the 3rd shift when they should be resting. We see this dynamic as resolving itself over time as 3.0 Tesla technology becomes the predominant standard of care and the 1.5 Tesla units are replaced with 3.0 Tesla units.

As requested, the projected utilization by MRI unit is below.

EMC – MRI Utilization Forecast

	Year 1	Year 2	Year 3
MRI Unit 1	3,701	3,612	3,690
MRI Unit 2	3,290	3,211	3,280
MRI Unit 3	3,290	3,211	3,280
Sub-Total	10,281	10,034	10,250
Proposed 3.0 Tesla MRI Unit	2,350	2,975	3,150
Total	12,631	13,009	13,400

10.) Section C, Need, Item 1 (Specific Criteria, Magnetic Resonance Imaging(2)).

The applicant notes the Georgia Dept. of Community Health does not maintain data for MRI units. Please provide the location of MRI units in the applicants Northwest Georgia service area.

Response

The location of the MRI units in northwest Georgia are as follows.

Hutcheson Medical Center
100 Gross Crescent Circle
Fort Oglethorpe, GA 30742

Battlefield Imaging
4700 Battlefield Parkway, Ste. 100
Ringgold, GA 30736

11.) Section C, Need, Item 1 (Specific Criteria, Magnetic Resonance Imaging(3)).

Please indicate if there is a waiting list for 3T appointments. In general, what is the wait time for an MRI at Erlanger ?

Response

We do not have precise information on this because we do not have a 3.0 Tesla MRI unit. However, generally speaking, we understand that these patients can be scheduled within 2-3 days. At *Erlanger Medical Center*, the average MRI patient wait time is about 2 weeks.

12.) Section C, Need, Item 1 (Specific Criteria, Magnetic Resonance Imaging(4)).

The chart of MRI utilization in Southeast Tennessee is noted. However, please revise the chart to include the Tesla strength of each MRI in the proposed service area and provide a replacement page for page 34.

Response

An updated page 34 is attached to this supplemental information.

13.) Section C, Need, Item 1 (Specific Criteria, Magnetic Resonance Imaging(7.b)).

The letter from the architect is noted. However, please submit a revised letter that demonstrates the proposed MRI will meet applicable federal standards, manufacturer specifications and licensing agencies' requirements.

Response

A revised architect letter is attached to this supplemental information.

14.) Section C, Need, Item 1 (Specific Criteria, Magnetic Resonance Imaging(7.g)) and Orderly Development, Item 1.

The list of transfer agreements in Attachments A-21 through A-24 is noted. However, the list is out of date and is expired. Please provide a current list.

Response

An updated list of patient transfer agreements is attached to this supplemental information.

15.) Section C, Need, Item 3.

The county level map of the applicant's service area is noted. However, please submit a revised map that provides legible county names. In addition, please label Georgia service area counties.

Response

A revised map is attached to this supplemental information.

16.) Section C, Item 1 (Need) and Section C, Item 5.

The table of primary acute hospital general utilization trends in the service area is noted. However, since the applicant is applying for a 3T MRI, please provide utilization for each of the most recent three years of data available for MRIs in the proposed service area.

If applicable, please describe any approved but unimplemented CONs for MRI services in the proposed service area.

Response

A table of the 3 year trend for MRI utilization is attached to this supplemental information.

Please note that *Parkridge Medical Center* currently has a CON application pending before the *Agency* for a 3.0 Tesla MRI Unit.

17.) Section C, Item 1 (Need) and Section C, Item 6 (Applicant's Utilization).

The general utilization for Erlanger Medical Center is noted. However, please respond to the question specific to MRI services.

Response

The utilization trend for MRI services at *Erlanger Medical Center* is as follows.

CY	Utilization	% Increase
2011	10,730	
2012	10,915	1.7%
2013	11,558	5.9%
2014	11,905	3.0%
2015	12,262	3.0%
2016	12,630	3.0%
2017	13,009	3.0%

18.) Section C, Item 4, Need.

Your response to this item is noted. Please complete the following chart. All the information requested can be obtained from the Department of Health population projections, TennCare website and U.S. Census website.

Demographic /Geographic Area	Bledsoe	Bradley	Grundy	Hamilton	Marion	MCMinn	Meigs	Polk	Rhea	Sequatchie	Primary Service	State of TN
Total Population-Current Year -2014												
Total Population-Projected Year -2018												
Total Population-% change												

Median Age												
Median Household Income												
TennCare Enrollees												
TennCare Enrollees as % of Total Pop.												
Persons Below Poverty Level												
Persons Below Poverty Level as % of Total												

Response

The demographic table is below.

	Bledsoe	Bradley	Grundy	Hamilton	Marion
Total Pop. - 2014	12,641	103,308	13,355	347,451	28,556
Total Pop. - 2018	12,599	107,481	13,293	353,577	28,992
Total Pop. - % Change	-0.3%	4.0%	-0.5%	1.8%	1.5%
Median Age	41	38	38	38	42
Median Household Income	$31,888	$40,614	$26,644	$46,544	$39,817
TennCare Enrollees	2,890	18,850	4,443	57,298	6,198
TennCare Enrollees As % Of Total Pop.	22.9%	18.2%	33.3%	16.5%	21.7%
Persons Below Poverty Level	2,920	18,389	3,873	56,287	5,483
Persons Below Poverty Level As % Of Total Pop.	23.1%	17.8%	29.0%	16.2%	19.2%

	McMinn	Meigs	Polk	Rhea	Sequatchie	Service Area	State Of Tennessee
Total Pop. - 2014	52,233	12,205	16,604	33,392	15,019	634,764	6,588,698
Total Pop. - 2018	54,203	12,643	16,588	34,790	16,004	650,170	6,833,509
Total Pop. - % Change	3.8%	3.6%	-0.1%	4.2%	6.6%	2.4%	3.7%
Median Age	39	38	41	38	37	39	38
Median Household Income	$38,944	$33,492	$37,235	$36,470	$33,181	$36,483	$44,140
TennCare Enrollees	10,660	2,700	3,529	8,090	3,574	118,232	1,241,028
TennCare Enrollees As % Of Total Pop.	20.4%	22.1%	21.3%	24.2%	23.8%	18.6%	18.8%
Persons Below Poverty Level	9,663	2,844	2,956	7,480	2,899	131,142	1,139,845
Persons Below Poverty Level As % Of Total Pop.	18.5%	23.3%	17.8%	22.4%	19.3%	20.7%	17.3%

19.) Section C, Economic Feasibility, Item 2.

The applicant notes the proposed project will be funded from cash reserves. However, the funding letter in the attachments notes the proposed project will be funded from operations. Since the historical data chart indicates the applicant has operated at a loss for the past 3 years, please revise the letter to indicate the project will be funded through cash reserves and resubmit.

Response

Applicant has traditionally considered cash reserves and operations to be synonymous, however, we have attached a revised page 49 to this supplemental information which identifies "Other" as the funding source, with the notation of funds from operations.

20.) Section C, Economic Feasibility, Item 1 (Historical & Projected Data Charts).

There appears to be errors in the Year One "total operating expense category" of the Projected Data Chart. Please revise and resubmit.

The applicant has not designated management fees in the historical and projected data charts. Please verify the applicant does not pay management fees to affiliates.

The Projected Data Chart is noted. Please complete the following table and place the tables on separate pages labeled 51A and 52A, respectively to be located after the Historical and Projected Data Charts.

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year___	Year___
1.	$_____	$_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
Total Other Expenses	$_____	$_____

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year___	Year___	*Year*___
1.	$_____	$_____	*$*_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
Total Other Expenses	$_____	$_____	$_____

The historical chart indicates the applicant has operated at a loss of approximately $12 million in 2011, $26 million in 2012, and $24 million in 2013. Please provide a Projected Data Chart for Erlanger Medical Center for Year One and Year Two of the proposed project.

Response

The other expense categories for the *Projected Data Chart* and the *Historical Data Chart;* as well as an updated *Projected Data Chart*, are attached to this supplemental information. Applicant does not have any expense related to management fees.

Concerning the observation that *Erlanger* has operated with a negative financial result for the last 3 years, we have attached a copy of the FY 2014 audit report which shows that a turn around situation has been effected. This audit report was just released to the public on Monday, September 22, 2014, and shows a positive from operations of $ 17,917,993.

21.) Section C, Economic Feasibility, Question 5.

The average gross charge, average deduction and average net charge are noted. However, please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project.

Response

The information is below.

	Year 1	Year 2
Average Gross Charge	3,614	3,774
Average Deduction From Revenue	3,184	3,248

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Average Net Charge	430	526

22.) Section C, Economic Feasibility, Question 6.A.

Please respond to this question specific to the proposed MRI service.

Response

Please see the list of patient charges for MRI services at *Erlanger Medical Center* attached to this supplemental information. Applicant does revise it's patient charge structure on a periodic basis (i.e.- usually annually) during the budget cycle each fiscal year. However, applicant does not anticipate any changes to existing patient charges specifically as a result of this project.

23.) Section C, Economic Feasibility, Question 6.B.

Please compare the proposed MRI Gross Charges per Procedure/Treatment by quartiles using the following table:

Gross Charges per Procedure/Treatment
By Quartiles
YEAR = 2013

Equipment Type	1st Quartile	Median	3rd Quartile
MRI	$1,570.39	$2,175.15	$3,498.94
Source: Medical Equipment Registry – 8/11/2014			

Response

As per the attached patient charge list for MRI services, *Erlanger Medical Center* has 27 charge items above the 3rd quartile, 41 charge items above the 2nd quartile (i.e.-Median), 14 items above the 1st quartile, and 34 items below the 1st quartile.

24.) Section C, Economic Feasibility, Question 7.

Please respond to this question specific to the proposed MRI service.

Response

Per the *Projected Data Chart*, in year 2 of this project the volume will be 2,975 procedures. This is 95 procedures more than is required per *Agency* criterion to reach the optimal capacity threshold of 2,880 procedures by year 3.

25.) Section C, Economic Feasibility, Question 8.

Please demonstrate the availability of sufficient cash flow until financial viability is achieved.

Response

Per the *Projected Data Chart* for this project, the net operating income will be $ 498,891 in Year 1 and $ 863,149 in year 2.

Concerning the observation that *Erlanger* has operated with a negative financial result for the last 3 years, we have attached a copy of the FY 2014 audit report which shows that a turn around situation has been effected. This audit report was just released to the public on Monday, September 22, 2014, and shows a positive from operations of $ 17,917,993.

26.) Section C, Economic Feasibility, Item 9.

Please indicate the percentage of total project revenue anticipated from each of TennCare/Medicaid or other state and federal sources for the proposal's first year of operation.

Please indicate how medically indigent patients will be served by the project.

Response

Anticipated revenue (gross charges) from Federal and State sources during year 1 of the project is as follows.

	Gross Revenue	% Of Total Revenue

Medicare	$ 2,640,828	31.1 %
TennCare	$ 413,165	4.9 %
	$ 3,053,993	36.0 %

27.) Section C, Economic Feasibility, Item 11.

One of the alternatives of the applicant is to continue to refer patients to providers in the service area with a 3T MRI. Please discuss why this alternative may not be a practicable alternative.

Response

As discussed in the CON application, *Erlanger Medical Center* is the safety net provider for southeast Tennessee. As such, because our mission is to serve all patients regardless of ability to pay, if we did not acquire the 3.0 Tesla MRI unit, the vulnerable populations which we serve may not be able to obtain this service if it is needed.

As an academic medical center and a teaching affiliate of the University of Tennessee College of Medicine, we need to acquire this technology in order to remain on the leading edge of our teaching mission.

Further, the continuity of care that is provided within the *Erlanger* system of care could be lost, to some extent, if we did not provide this service.

For these reasons, it is not practical to continue to refer our patients to other providers.

28.) Section C, Contribution To Orderly Development, Item 3 (Staffing).

Please provide the current and proposed staffing pattern for all employees and compare the staff salaries to the prevailing wage patterns in the service area. Also, please provide the reference for the area wide wages.

Position Title	Current FTEs Existing 3 MRIs	Proposed FTEs for 3T MRI	Net Change	EMC Average Wage	Area-wide Wage Average

Total					

Response

The information is below.

Position Title	Current FTEs Existing 3 MRIs	Proposed FTEs for 3T MRI	Net Change	EMC Average Wage	Area-wide Wage Average
RT	8	2	+2	26.31	29.52
RN	1	0	0	29.39	27.77
PCT	3	2	+2	11.10	12.10
Total	12	4	+4		

29.) Section C, Contribution To Orderly Development, Items 8 and 9.

The applicant has responded N/A to items 8 and 9. Please provide a narrative response addressing the question.

Response

As requested, the narrative responses appear below.

Item 8

There have been no final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant.

Item 9

There have been no final civil or criminal judgments for fraud or theft against the applicant, which includes any person or entity with more than a 5% ownership interest in the project.

30.) Outstanding Project Update.

A brief two to three sentence update will be appreciated regarding the progress on the implementation of the following projects:

CN1207-034A - Renovation, upgrade and modernization of adult operating rooms and addition of 4 OR's.
CN0405-047A - Erlanger East Expansion.
CN1012-056A.- Erlanger North Conversion of 30 acute care beds to 30 skilled nursing beds & initiation of skilled nursing services.

Please include where the project currently stands (i.e., what phase) in the implementation process, when the projected is expected to be completed and the expiration date of the Certificate of Need.

Response

Updated information for these projects is below.

CN1207-034A -- This project is progressing and is currently about 65% complete. It will be completed by the expiration date of November 1, 2015.
CN0405-047A -- The expansion of *Erlanger East* was approved for an extension until December 1, 2016, at the *Agency* meeting on Wednesday, September 24, 2014.
CN1012-056A -- The CON for this project was returned to the *Agency* in August, 2014.

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A F F I D A V I T

STATE OF TENNESSEE |
|
COUNTY OF HAMILTON |

NAME OF FACILITY Erlanger Medical Center

I, Joseph M. Winick, after first being duly sworn, State under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

SIGNATURE

SWORN to and subscribed before me this 23 of September (Month), 2014 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

SHELIA HALL
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

Shelia Hall
NOTARY PUBLIC

My Commission expires June 9 (Month / Day), 2018.

TABLE OF ATTACHMENTS

SUPPLEMENTAL- 1

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** NOTE - The attachments are paginated and the page number begins with "A". The page number appears in the upper right hand corner of the page.

SUPPLEMENTAL- 1

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ATTACHMENTS

A.	Corporation (Not-for-Profit)	
B.	Governmental (State of TN or Political Subdivision)	X
C.	Joint Venture	
D.	Limited Liability Company	
E.	Other (Specify)	

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

-- A copy of the enabling legislation along with a copy of the certification by the Tennessee Secretary of State is attached at the end of this Application.

-- Please note that *Erlanger Health System* is a single legal entity and *Erlanger Medical Center* is an administrative unit of *Erlanger Health System*.

5. **Name of Management / Operating Entity (if applicable).**

** *Not Applicable.* **

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. **Legal Interest in the Site of the Institution**
(Check One)

A.	Ownership	X
B.	Option to Purchase	
C.	Lease of _____ Years	
D.	Option to Lease	
E.	Other (Specify)	

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

Jill Gail Middleton
Call 209-6444
To pick up.

ADDRESS NEW OWNER(S) AS FOLLOWS:	SEND TAX BILLS TO:	MAP PARCEL NUMBER
Chattanooga-Hamilton (NAME)	Same (NAME)	Pt. 146A-J-1
County Hospital Authority (STREET ADDRESS OR ROUTE NUMBER)	(STREET ADDRESS)	(Exempt Agency)
975 E. 3rd Street (CITY) (STATE) (ZIP)	(CITY) (STATE) (ZIP)	
Chattanooga, TN 37403		

PTA 00-194

QUITCLAIM DEED

IN CONSIDERATION of One ($1.00) Dollar and other valuable considerations paid, the receipt of all of which is hereby acknowledged, CITY OF CHATTANOOGA, TENNESSEE, a Municipal Corporation, and HAMILTON COUNTY, a Constitutional County of the STATE OF TENNESSEE do hereby sell, transfer and convey and forever quitclaim unto CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY, a Tennessee Corporation, all the right, title, and interest it has in and to the following described real estate located in the City of Chattanooga of Hamilton County, Tennessee:

Beginning at the intersection of the Northwest line of Cleveland Avenue with the Northeast line of Blackford Street; thence North 68 degrees 24 minutes 39 seconds West, with and along the Northeast line of Blackford Street, 130.57 feet; thence North 21 degrees 28 minutes 39 seconds East 172.37 feet; thence South 62 degrees 19 minutes 23 seconds East 173.16 feet; thence South 24 degrees 50 minutes 27 seconds West 122.81 feet to a point in the Northwest line of Cleveland Avenue; thence South 69 degrees 03 minutes 53 seconds West, with and along the Northwest line of Cleveland Avenue, 46.54 feet to the point of beginning, according to Plat of Survey prepared by Betts-Lutin Consultants, Inc., Engineer's File No. 8716-1-24A, dated July 24, 1979.

The source of Grantor's interest is found in Deed recorded in Book 2606, Page 834, in the Register's Office of Hamilton County, Tennessee.

Subject to any governmental zoning and subdivision ordinances or regulations in effect thereon.

The grantee herein assumes and agrees to pay all taxes assessed against said real estate for the year 2000.

Instrument: 2000120100027
Book and Page: GI 5729 702
Deed Recording Fe $12.00
Data Processing F $2.00
Probate Fee $1.00 XMPT
Total Fees: $14.00
User: KLYNN
Date: 01-DEC-2000
Time: 08:24:01 A
Contact: Pam Hurst
Hamilton County Tennessee

Prepared By
WILLIAM DAVID JONES
ATTORNEY AT LAW
513 Georgia Avenue
CHATTANOOGA,TN 37403

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A-3
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Grantor and grantee acknowledge that this Deed was prepared by information furnished by them. No title examination has been made and neither William David Jones nor Pioneer Title Agency, Inc., shall have any liability for the status of title to the property or for the accuracy of such information.

WITNESS our hands on this the 28th day of November, 2000.

ATTEST

Auditor

THE CITY OF CHATTANOOGA, TENNESSEE

BY: Jon Kinsey
Jon Kinsey
Mayor

ATTEST

County Clerk

HAMILTON COUNTY, TENNESSEE

BY:
Claude Ramsey
County Executive

STATE OF TENNESSEE
COUNTY OF HAMILTON

Before me, Shirley Paul, of the state and county aforesaid, personally appeared JON KINSEY, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who upon oath, acknowledged himself to be the Mayor of the City of Chattanooga, Tennessee (or other officer) authorized to execute the instrument of the City of Chattanooga, Tennessee, the within named bargainor, a Municipal Corporation, and that he as such Mayor, executed the foregoing instrument for the purpose therein contained, by signing the name of the corporation by himself as Mayor.

WITNESS my hand and seal, at office in Chattanooga, Tn., this 21st day of November, 2000.

Notary Public

My Commission Expires: 2/05/02

SUPPLEMENTAL- 1

September 26, 2014
11:40am

Book and Page: GI 5729 704

STATE OF TENNESSEE
COUNTY OF HAMILTON

Before me, Rebecca F. Browder, of the state and county aforesaid, personally appeared CLAUDE RAMSEY, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who upon oath, acknowledged himself to be the County Executive of Hamilton County, Tennessee, (or other officer) authorized to execute the instrument of Hamilton County, Tennessee, the within named bargainor, a Constitutional County, and that he as such County Executive, executed the foregoing instrument for the purpose therein contained, by signing the name of the corporation by himself as County Executive.

WITNESS my hand and seal, at office in Chattanooga, TN, this 18th day of November, 2000.

Rebecca F. Browder
Notary Public

My Commission Expires: December 12, 2002

STATE OF TENNESSEE
COUNTY OF HAMILTON

I hereby swear or affirm that the actual consideration for this transfer or value of the property transferred, whichever is greater, is $ Exempt -0-, which amount is equal to or greater than the amount which the property transferred would command at a fair and voluntary sale.

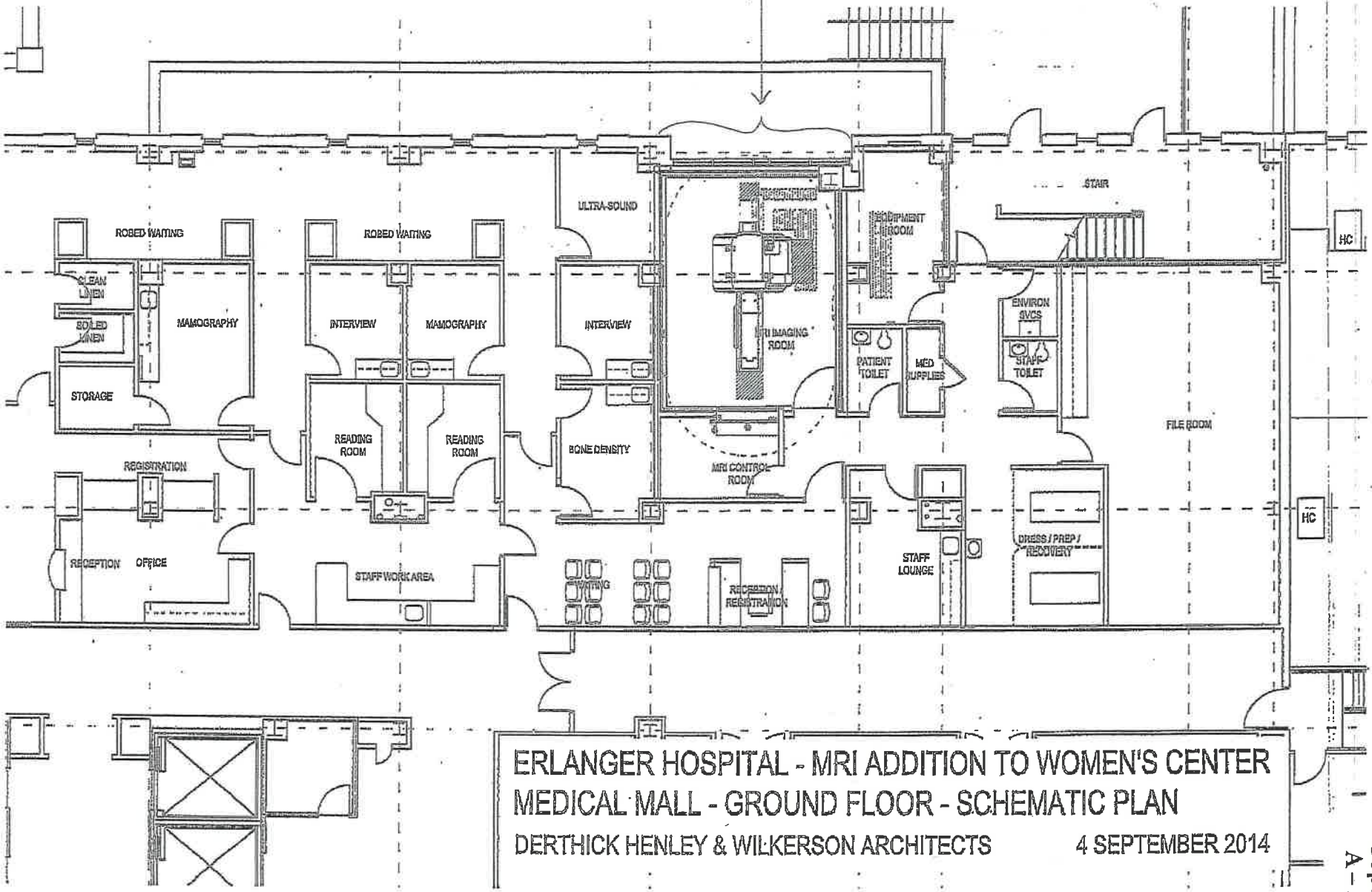
Affiant

Subscribed and sworn to before me on this the _____ day of _____, 2000.

Notary Public

My Commission Expires: _____

** 3.0 Tesla MRI Unit **



ERLANGER HOSPITAL - MRI ADDITION TO WOMEN'S CENTER

MEDICAL MALL - GROUND FLOOR - SCHEMATIC PLAN

DERTHICK HENLEY & WILKERSON ARCHITECTS 4 SEPTEMBER 2014

SUPPLEMENTAL - 1

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EHS – Analysis Of MRI Utilization In Southeast Tennessee

County	Type	Facility Name	Tesla Strength	No. Of MRI Units	Total Proc's	Avg. Proc's Per Unit
Bradley	HOSP	Skyridge Medical Center	1.5	1.0	2,302	2,302
Bradley	HOSP	Skyridge Medical Center - Westside	1.5	2.0	1,818	909
Hamilton	ODC	Chattanooga Imaging Downtown	1.5	2.0	1,540	770
Hamilton	RPO	Chattanooga Imaging East	1.5	1.0	2,822	2,822
Hamilton	RPO	Chattanooga Imaging Hixson	1.5	1.0	2,386	2,386
Hamilton	ODC	Chatt. O/P Center	3.0 (2)	2.0	7,292	3,646
Hamilton	H-Imaging	Erlanger East Imaging	1.5	1.0	568	568
Hamilton	HOSP	Erlanger Medical Center	1.5	3.0	11,558	3,853
Hamilton	HOSP	Memorial Hixson Hospital	1.5	2.0	2,488	1,244
Hamilton	HOSP	Memorial Hospital	3.0 (2)	3.0	4,356	1,452
Hamilton	H-Imaging	Memorial Ooltewah Imaging Center	3.0	1.0	1,049	1,049
Hamilton	HOSP	Parkridge East Hospital	1.5	1.0	1,024	1,024
Hamilton	HOSP	Parkridge Medical Center	1.5	1.0	2,054	2,054
Hamilton	RPO	Tennessee Imaging and Vein Center	1.5	1.0	3,165	3,165
Marion	HOSP	Parkridge West Hospital	1.5	1.0	884	884
McMinn	HOSP	Starr Regional Medical Center	1.5	1.0	2,437	2,437
McMinn	HOSP	Starr Regional Medical Center - Etowah	1.5	1.0	479	479
Polk	HOSP	Copper Basin Medical Center	1.5	0.2	250	250
Rhea	HOSP	Rhea Medical Center	1.5	1.0	1,481	1,481
		Sub - Total		26.2	49,953	1,907
Bradley	PO	Cleveland Imaging	1.5	1.0	3,509	3,509
Hamilton	PO	Chattanooga Bone & Joint Surgeons, PC	1.5	1.0	841	841
Hamilton	PO	Chattanooga Orthopaedic Group PC	1.5	1.0	5,340	5,340
Hamilton	PO	Neurosurgical Group of Chattanooga, P.C.	1.5	1.0	1,198	1,198
		Sub - Total		4.0	10,888	2,722
		Total		30.2	60,841	2,015

(1) -- MRI utilization data obtained from the Tennessee Health Services Agency website. Utilization data is for 2013.

(2) -- Please note that each of these providers has one MRI unit which is 3.0 Tesla strength.

While some of the MRI units in the regional service area are below the threshold of 2,880 procedures per unit, as the safety net provider in Southeast Tennessee, *EMC* has a significant need to provide the 3.0 Tesla imaging technology to the low income, uninsured and vulnerable populations which we serve. Without *Erlanger* having this newer 3.0 Tesla technology these patient categories would likely not have access while it is becoming the standard of care for some medical specialties.

5. **Need Standards For Specialty MRI Units.**

a. Dedicated fixed or mobile breast MRI unit.

b. Dedicated fixed or mobile Extremity MRI Unit.

EHS – Analysis Of MRI Utilization In Southeast Tennessee

			CY 2013			CY 2012			CY 2011		
County	Type	Facility Name	MRI Units	Proc's	Avg. Per Unit	MRI Units	Proc's	Avg. Per Unit	MRI Units	Proc's	Avg. Per Unit
Bradley	HOSP	Skyridge Medical Center	1.0	2,302	2,302	1.0	2,499	2,499	1.0	2,584	2,584
Bradley	HOSP	Skyridge Medical Center - Westside	2.0	1,818	909	2.0	2,493	1,247	2.0	3,214	1,607
Hamilton	ODC	Chattanooga Imaging Downtown	2.0	1,540	770	2.0	2,035	1,018	2.0	2,044	1,022
Hamilton	RPO	Chattanooga Imaging East	1.0	2,822	2,822	1.0	2,850	2,850	2.0	4,552	2,276
Hamilton	RPO	Chattanooga Imaging Hixson	1.0	2,386	2,386	1.0	2,230	2,230	1.0	2,117	2,117
Hamilton	ODC	Chatt. O/P Center	2.0	7,292	3,646	1.0	6,465	6,465	1.0	6,045	6,045
Hamilton	H-Imaging	Erlanger East Imaging	1.0	568	568	1.0	704	704	1.0	1,275	1,275
Hamilton	HOSP	Erlanger Medical Center	3.0	11,558	3,853	3.0	10,915	3,638	3.0	10,730	3,577
Hamilton	HOSP	Memorial Hixson Hospital	2.0	2,488	1,244	2.0	2,836	1,418	2.0	4,048	2,024
Hamilton	HOSP	Memorial Hospital	3.0	4,356	1,452	3.0	4,096	1,365	3.0	8,211	2,737
Hamilton	H-Imaging	Memorial Ooltewah Imaging Center	1.0	1,049	1,049	1.0	1,050	1,050	1.0	1,286	1,286
Hamilton	HOSP	Parkridge East Hospital	1.0	1,024	1,024	1.0	919	919	1.0	934	934
Hamilton	HOSP	Parkridge Medical Center	1.0	2,054	2,054	1.0	2,496	2,496	1.0	2,320	2,320
Hamilton	RPO	Tennessee Imaging & Vein Center	1.0	3,165	3,165	1.0	3,074	3,074	1.0	2,615	2,615
Marion	HOSP	Parkridge West Hospital	1.0	884	884	1.0	953	953	1.0	884	884
McMinn	HOSP	Starr Regional Medical Center	1.0	2,437	2,437	1.0	2,295	2,295	1.0	2,112	2,112
McMinn	HOSP	Starr Regional Medical Center - Etowah	1.0	479	479	1.0	1,078	1,078	1.0	1,028	1,028
Polk	HOSP	Copper Basin Medical Center	0.2	250	250				0.2	239	1,195
Rhea	HOSP	Rhea Medical Center	1.0	1,481	1,481	1.0	1,530	1,530	1.0	1,289	1,289
		Sub - Total	26.2	49,953	1,907	25.0	50,518	2,021	26.2	57,527	2,196
Bradley	PO	Cleveland Imaging	1.0	3,509	3,509	1.0	2,769	2,769	1.0	668	668
Hamilton	PO	Chattanooga Bone & Joint Surgeons, PC	1.0	841	841	1.0	1,021	1,021	1.0	1,119	1,119
Hamilton	PO	Chattanooga Orthopaedic Group PC	1.0	5,340	5,340	1.0	5,332	5,332	1.0	5,698	5,698
Hamilton	PO	Neurosurgical Group of Chattanooga, P.C.	1.0	1,198	1,198	1.0	1,405	1,405	1.0	1,388	1,388
		Sub - Total	4.0	10,888	2,722	4.0	10,527	2,632	4.0	8,873	2,218
		Total	30.2	60,841	2,015	29.0	61,045	2,105	30.2	66,400	2,199

(1) – MRI utilization data obtained from the Tennessee Health Services Agency website. Utilization data is for 2013.

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September 26, 2014
11:40am

22 September 2014

Mr. Gary Orrell, Construction Manager
Erlanger Health System
975 East Third Street
Chattanooga, TN

RE: Renovation for MRI Unit
Ground Floor – Medical Mall

Dear Mr. Orell:

I have attached a drawing titled "Schematic Plan" dated 4 September 2014. The budget indicating a construction cost of $1,030,203 is reasonable considering the complexity for this type of construction. Furthermore the scheduled completion of the work on 18 August 2015 includes reasonable time for all activities associated with this project.

The design for this renovation will meet all known current building codes, TDOH licensing standards, and will follow all requirements for health facility construction including the joint AIA/Federal Standards. Furthermore, the design will incorporate the manufacturer's specifications for preparing the room to facilitate the installation of their equipment.

Sincerely yours,

William H. Wilkerson

1001 Carter Street | Chattanooga, Tennessee 37402 | voice 423.266.4816 | fax 423.267.8830 | www.dhw-architects.com

Vendor (Other Party)	Contract Type	Effective Date	Expiration Date	Description
Sweetwater Dialysis Center	Patient Transfer Agreement	6/19/2009	Evergreen	Provide Renal Transplantation and other services to Clinic patients
Harbin Clinics LLC	Patient Transfer Agreement	10/16/2012	10/15/2014	Renal Transplant Patient Transfer
Dialysis Clinic, Inc	Patient Transfer Agreement	3/23/1998	Evergreen	DCI Patient Transfer Agreements (all facilities -- see attachments)
Rhea County Medical Center	Patient Transfer Agreement	9/1/1989	Evergreen	Renal Transplant Services (Transfer)
Chattanooga Kidney Centers, LLC and Chattanooga Kidney Centers 58, LLC and Chattanooga Kidney Centers North, LLC and Kidney Center of Missionary Ridge	Patient Transfer Agreement	10/10/2011	10/9/2014	Renal Transplant Patient Transfer Agreement
Kindred Hospital	Patient Transfer Agreement	10/1/2001	Evergreen	Patient Transfer Agreement
Life Care Center of Collegedale	Patient Transfer Agreement	1/1/1995	Evergreen	Patient Transfer Agreement
Marshall Medical Center North	Patient Transfer Agreement	2/1/2000	Evergreen	Pediatric Patient Transfer
Life Care Center of Red Bank	Patient Transfer Agreement	1/1/1995	Evergreen	Patient Transfer Agreement
Tender Loving Care	Patient Transfer Agreement	1/1/1995	Evergreen	Hospice Transfer
LaFayette Health Care	Patient Transfer Agreement	1/31/1995	Evergreen	Patient Transfer Agreement
Jefferson Memorial Hospital	Patient Transfer Agreement	10/22/2004	Evergreen	Patient Transfer Agreement
Mountain Creek Manor	Patient Transfer Agreement	1/20/1995	Evergreen	Patient Transfer Agreement
Murphy Medical Center	Patient Transfer Agreement	4/1/2000	Evergreen	Pediatric Patient Transfer Agreement
Northside Hospital	Patient Transfer Agreement	4/10/1992	Evergreen	Patient Transfer Agreement
Renaissance Rehabilitation	Patient Transfer Agreement	4/26/1990	Evergreen	Patient Transfer Agreement
Rivermont Convalescent Center	Patient Transfer Agreement	1/25/1995	Evergreen	Patient Transfer
The Health Center at Standifer Place	Patient Transfer Agreement	6/18/2012	6/17/2015	Patient Transfer
Shepherd Hills Health Care Center	Patient Transfer Agreement	1/25/1995	Evergreen	Patient Transfer Agreement
Methodist Medical Center	Patient Transfer Agreement	2/6/2002	Evergreen	Patient Transfer Agreement
Brookewood Medical Center	Patient Transfer Agreement	6/27/2012	6/26/2015	Patient Transfer Agreement
Continuum Care Corporation d/b/a Spring City Health Care Center	Patient Transfer Agreement	2/1/1999	Evergreen	Patient Transfer Agreement
Bledsoe Community Medical Center	Patient Transfer Agreement	6/27/2012	6/26/2015	Patient Transfer
The University of Tennessee Medical Center	Patient Transfer Agreement	5/29/2002	Evergreen	Patient Transfer Agreement
Erlanger Bledsoe	Patient Transfer Agreement	10/1/2001	Evergreen	Patient Transfer Agreement
Cookeville Regional Medical Center	Patient Transfer Agreement	2/10/2010	Evergreen	Patient Transfer Agreement
Scott County Hospital	Patient Transfer Agreement	1/11/2001	Evergreen	Patient Transfer Agreement

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Vendor (Other Party)	Contract Type	Effective Date	Expiration Date	Description
Wellmont Health Systems	Patient Transfer Agreement	6/30/2001	Evergreen	Patient Transfer Agreement
Laughlin Memorial Hospital, Inc	Patient Transfer Agreement	11/23/2011	11/22/2014	Patient Transfer Agreement
Fort Sanders Park West Medical Center	Patient Transfer Agreement	10/22/1999	Evergreen	Patient Transfer Agreement
Ft Oglethorpe Nursing Home	Patient Transfer Agreement	1/12/2012	1/11/2015	Patient Transfer Agreement
Johnson City Medical Center	Patient Transfer Agreement	5/29/2002	Evergreen	Patient Transfer Agreement
Life Care Center of Chattanooga	Patient Transfer Agreement	1/25/1995	Evergreen	Patient Transfer Agreement
St Barnabas Nursing Home	Patient Transfer Agreement	1/25/1995	Evergreen	Patient Transfer Agreement
North Jackson Hospital	Patient Transfer Agreement	2/1/2000	Evergreen	Pediatric Patient Transfer Agreement
National Health Care of Rossville	Patient Transfer Agreement	5/17/2012	Evergreen	Patient Transfer Agreement
National Health Care of Fort Oglethorpe	Patient Transfer Agreement	5/22/2012	Evergreen	Patient Transfer Agreement
National Healthcare of Dunlap	Patient Transfer Agreement	6/20/2012	6/19/2015	Patient Transfer Agreement
National Health Care of Athens	Patient Transfer Agreement	5/15/2012	Evergreen	Patient Transfer Agreement
Shriners Hospitals for Children	Patient Transfer Agreement	7/1/2000	Evergreen	Pediatric Patient Transfer Agreement
Rhea Medical Center	Patient Transfer Agreement	2/6/2002	Evergreen	Patient Transfer Agreement
Siskin Hospital for Physical Rehabilitation	Patient Transfer Agreement	2/9/1990	Evergreen	Shared Services
Alexian Village of Chattanooga	Patient Transfer Agreement	1/1/1995	Evergreen	Patient Transfer Agreement
Blount Memorial Hospital	Patient Transfer Agreement	2/7/2001	Evergreen	Pediatric Patient Transfer Agreement
Columbia Indian Path Medical Center	Patient Transfer Agreement	1/13/1997	Evergreen	Patient Transfer Agreement
Columbia East Ridge Hospital	Patient Transfer Agreement	3/31/1998	Evergreen	Pediatric Patient Transfer Agreement
East Ridge Hospital	Patient Transfer Agreement	10/22/1996	Evergreen	Patient Transfer Agreement
NovaMed Eye and Laser Surgery, Center of	Patient Transfer Agreement	6/27/2002	Evergreen	Patient Transfer Agreement
Jamestown Regional Medical Center, f/k/a Fentress County Hospital	Patient Transfer Agreement	5/14/2012	Evergreen	Patient Transfer Agreement
Healthsouth Chattanooga Surgery Center	Patient Transfer Agreement	4/13/1999	Evergreen	Patient Transfer Agreement
Harton Regional Medical Center	Patient Transfer Agreement	12/8/2011	12/7/2014	Patient Transfer Agreement
St Mary's Health System, Inc	Patient Transfer Agreement	4/1/2003	Evergreen	Patient Transfer Agreement
Riverview Regional Medical Center North, f/k/a Smith County Hospital	Patient Transfer Agreement	12/5/2011	12/4/2014	Patient Transfer Agreement
Redmond Regional Medical Center	Patient Transfer Agreement	1/17/2012	1/16/2015	Patient Transfer Agreement
Murray Medical Center	Patient Transfer Agreement	12/5/2011	12/4/2014	Patient Transfer Agreement
Medical Center of Manchester	Patient Transfer Agreement	4/19/2012	4/18/2015	Patient Transfer Agreement
Lincoln County Health System	Patient Transfer Agreement	11/30/2011	11/29/2014	Patient Transfer Agreement

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Vendor (Other Party)	Contract Type	Effective Date	Expiration Date	Description
Hamilton Medical Center	Patient Transfer Agreement	11/22/2011	11/21/2014	Patient Transfer
Fannin Regional Hospital	Patient Transfer Agreement	6/18/2012	6/17/2015	Patient Transfer
Cumberland Medical Center, Inc	Patient Transfer Agreement	12/2/2011	12/1/2014	Patient Transfer
Copper Basin Medical Center	Patient Transfer Agreement	12/1/2011	11/30/2014	Patient Transfer Agreement
Chatuge Regional Hospital	Patient Transfer Agreement	12/1/2011	11/30/2014	Patient Transfer Agreement
Highlands Medical Center	Patient Transfer Agreement	4/25/2012	12/31/2014	Patient Transfer Agreement
Gordon Hospital	Patient Transfer Agreement	7/1/2012	Evergreen	Patient Transfer Agreement
Chattanooga Rehabilitation Hospital	Patient Transfer Agreement	7/25/2012	7/24/2015	Patient Transfer Agreement
Vanderbilt University Medical Center	Patient Transfer Agreement	7/1/2008	Evergreen	Burn Patient Transfer
Physician Surgery Center of Chattanooga	Patient Transfer Agreement	4/2/2012	Evergreen	Patient Transfer
Parkridge Medical Center	Patient Transfer Agreement	5/18/2012	Evergreen	Patient Transfer
Renaissance Surgery Center	Patient Transfer Agreement	2/16/2012	2/15/2015	Patient Transfer Agreement
East Tennessee Regional Hospitals	Patient Transfer Agreement	9/23/2014	Evergreen	Disaster Aid Agreement (Memorial Health Care; Parkridge Medical Center, Inc; Southern Tennessee Medical Center/Emerald Hodgson Hospital; Copper Basin Medical Center; Athens Regional Medical Center/Woods Memorial Hospital; Grandview Medical Center; Rhea Medical Center; Skyridge Medical Center)

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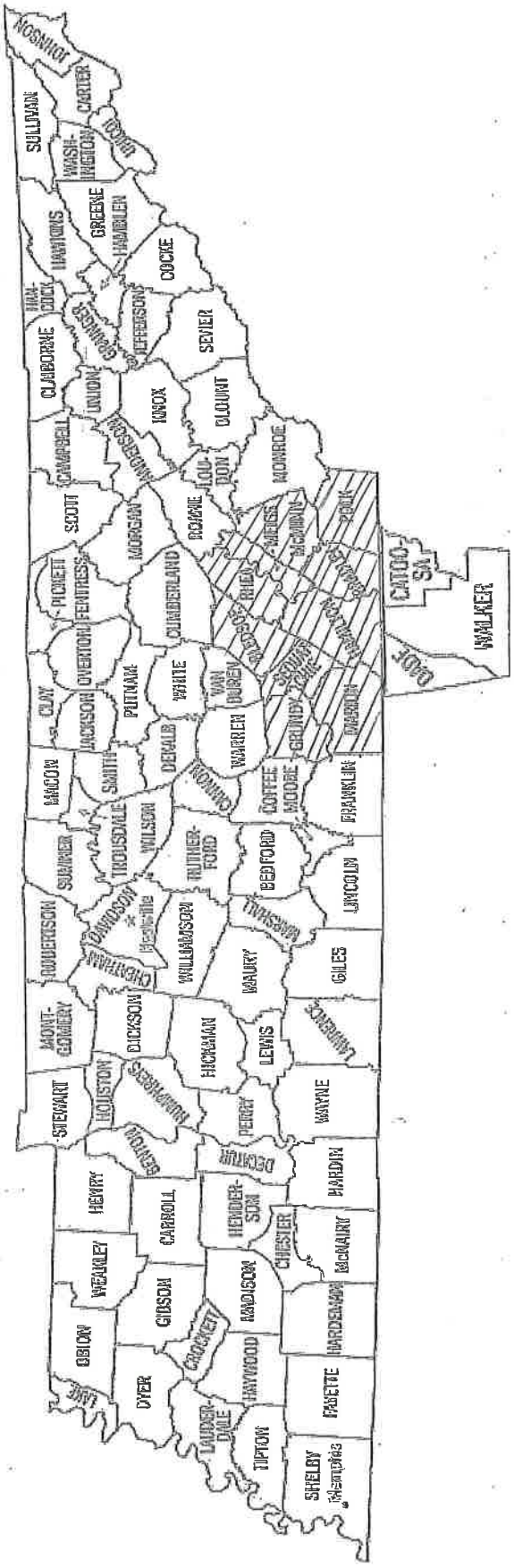
JOHNSON
SULLIVAN
CARTER
UNICOI
WASHINGTON
HAWKINS
GREENE
HAMBLEN
COCKE
HANCOCK
GRAINGER
JEFFERSON
SEVIER
CLAIBORNE
UNION
KNOX
BLOUNT
CAMPBELL
ANDERSON
LOUDON
MONROE
SCOTT
MORGAN
ROANE
MEIGS
POLK
CATOO-SA
PICKETT
FENTRESS
CUMBERLAND
RHEA
BRADLEY
HAMILTON
WALKER
OVERTON
SEQUATCHIE
CLAY
JACKSON
PUTNAM
WHITE
VAN BUREN
GRUNDY
MARION
DEKALB
WARREN
MACON
SMITH
COFFEE
MOORE
FRANKLIN
SUMNER
TROUSDALE
WILSON
RUTHERFORD
BEDFORD
LINCOLN
ROBERTSON
DAVIDSON
Nashville
WILLIAMSON
MARSHALL
MAURY
GILES
CHEATHAM
MONTGOMERY
DICKSON
HICKMAN
LEWIS
LAWRENCE
STEWART
HOUSTON
HUMPHREYS
PERRY
WAYNE
BENTON
DECATUR
HENRY
CARROLL
HENDERSON
CHESTER
HARDIN
WEAKLEY
GIBSON
MADISON
MCNAIRY
OBION
CROCKETT
HARDEMAN
DYER
HAYWOOD
FAYETTE
LAKE
LAUDERDALE
TIPTON
SHELBY
Memphis

PROJECTED DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in ___July___ (Month).

		Year 1	Year 2
A.	Utilization Data	2,350	2,975
	(Specify Unit Of Measure) MRI Procedures		
B.	Revenue From Services To Patients		
	1. Inpatient Services		
	2. Outpatient Services	8,492,065	11,227,918
	3. Emergency Services		
	4. Other Operating Revenue		
	(Specify) _____		
	Gross Operating Revenue	8,492,065	11,227,918
C.	Deductions From Operating Revenue		
	1. Contractual Adjustments	6,569,444	8,758,777
	2. Provision For Charity Care	115,542	152,766
	3. Provision For Bad Debt	251,282	332,236
	Total Deductions	6,936,268	9,243,779
	NET OPERATING REVENUE	1,555,797	1,984,139
D.	Operating Expenses		
	1. Salaries And Wages	240,435	250,774
	2. Physician's Salaries And Wages		
	3. Supplies	19,580	25,586
	4. Taxes		
	5. Depreciation	431,301	431,301
	6. Rent		
	7. Interest - Other Than Capital		
	8. Management Fees:		
	a. Fees To Affiliates		
	b. Fees To Non-Affiliates		
	9. Other Expenses	365,590	413,329
	(Specify) Contrast Agent, Svc. Contract, etc.		
	Total Operating Expenses	1,056,906	1,120,990
E.	Other Revenue (Expenses) – Net		
	(Specify) _____		
	NET OPERATING INCOME (LOSS)	498,891	863,149
F.	Capital Expenditures		
	1. Retirement Of Principal		
	2. Interest		
	Total Capital Expenditures		
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	498,891	863,149

PROJECTED DATA CHART - OTHER EXPENSES

	Year 1	Year 2
Other Expenses Category		
1.) MRI Contrast Agent	116,964	153,358
2.) Injector	3,800	3,939
3.) Service Agreement	160,225	166,073
4.) Corporate Overhead Allocation	84,601	89,959
5.)		
6.)		
7.)		
Total - Other Expenses	365,590	413,329

HISTORICAL DATA CHART – Other Expenses

		2013	2012	2011
	Purchased Services	111,584,374	102,702,749	91,070,211
	Utilities	9,736,115	9,757,309	9,557,545
	Drugs	32,921,513	32,551,755	36,189,380
	Insurance and Taxes	2,198,654	4,467,158	3,340,749
	Total - Other Expenses	156,440,656	149,478,971	140,157,885
Purchased Services		**111,584,374**	**102,702,749**	**91,070,211**
620142	Restricted Fund Expense	76,633	237,126	148,628
620252	Physician Fees	20,510,257	20,113,740	20,272,910
620302	Consulting	8,018,102	1,668,100	1,271,450
620322	Legal Fees	2,393,527	1,869,626	785,035
620332	Audit Fees	194,406	211,360	196,298
620352	Architect & Eng Fees	182,585	123,174	37,787
620492	Time & Mat Contract	3,023,421	3,659,430	3,533,283
620502	Dietary	621,402	516,296	477,784
620522	Unscheduled Maint	4,687,799	3,374,335	3,134,217
620010	Plz Surgery Minority Interest		-149,843	
620523	CUC Delivery/Vehicle Expense	32,607	31,248	82,607
620532	Advertising	2,555,479	2,198,138	2,406,864
620542	Purchased Services	29,055,253	31,214,122	25,722,656
620562	Purchased Maint	3,220,291	3,908,269	3,791,437
620572	Freight Charges	314,512	275,027	217,953
620573	CUC Penalties	1,425	2,561	951
620574	CUC Late Fees	4,971	2,000	2,993
620582	Collection Fees	738,913	162,324	468,258
620602	Lab Outside Fees	3,205,690	3,709,926	3,456,266
620622	Computer Services	4,970,519	4,501,692	4,147,745
620652	Rent-Office			439,367
620653	CUC Rent - Parking Spaces			1,200
620672	Rent/Lease Copier			19,455
620682	Micro Maint	74,128	95,567	129,433
620692	Equipment Rental	3,033,690	3,246,154	2,608,757
620792	Contracted Services	18,663,071	15,797,297	11,681,704
620892	Membership & Dues	1,167,871	1,398,184	1,055,383
620902	Special Classes	27,957	10,365	41,096
620912	Licenses & Fees	1,281,524	1,175,538	1,537,526
620922	Development Costs	176,338	45,716	-6,829
620932	Professional Education	1,045,961	1,059,982	1,073,367
620933	CUC Meals & Entertainment	11,491	9,910	12,154
620952	Local Travel	323,282	315,197	292,080
620953	CUC Field Trip Expense	12,657	9,764	8,936
620982	Business Courtesy	44,274	34,226	16,407
621182	Asbestos Expense	128,761	31,350	55,132
621202	Recruiting	670,202	634,222	776,115
621272	Resident Education	295,055	311,609	275,367
621532	Public Relations	487,507	474,619	545,685
621972	Patient parking	217,813	186,556	138,687
622002	Med/Prof Housing Expense	115,000	237,841	214,070
Utilities		**9,736,115**	**9,757,309**	**9,557,545**
640702	Billed Utilities	-461,256	-412,326	-593,578
640712	Electricity	5,927,593	6,111,788	5,984,394
640722	Gas	1,559,592	1,552,861	1,889,085
640732	Water	1,136,971	1,050,175	983,945
640742	Oil	6,450	10,816	9,152
640752	Storm Water Fees	39,551	53,048	1,284,547
640882	Telephone	1,527,215	1,390,947	
				36,189,380
Drugs		**32,921,513**	**32,551,755**	36,189,380
630403	Drugs	32,921,513	32,551,755	
				3,340,749
Insurance and Taxes		**2,198,654**	**4,467,158**	1,916,085
670847	Self Insurance Expense	952,825	1,686,257	1,073,443
670857	Insurance	1,207,188	2,695,711	332,251
680878	CUC Taxes - Sales	629	11,966	16,701
680880	Gross Receipts Tax	38,012	73,224	2,269

Charge Code	Description	Charge Amount	CPT / HCPCS Code
34500033	MRA ABD W/O CONTRAST	1,736.00	74185
34500041	MRA LOWER EXT W/O CONTRAST	1,889.00	73725
34500066	MRA UPPER EXT W OR WO	3,066.00	73225
34500074	MRI ABDOMEN W/O	2,453.00	74181
34500108	MRI BRAIN W/CONTRAST	3,831.00	70552
34500116	MRI BRAIN W/O CONTRAST	2,783.00	70551
34500124	MRI BRAIN W/WO CONTRAST	4,973.00	70553
34500132	MRI CHEST W/O CONTRAST	1,225.00	71550
34500140	GADOLINIUM INJECTION PER ML	11.00	A9579
34500165	MRI LOWER EXT ANY JNT W/O	2,818.00	73721
34500173	MRI LOWER EXT NOT JNT W/WO	3,498.00	73720
34500207	MRI ORBIT/FACE/NECK,W/O CONTRA	2,871.00	70540
34500215	MRI PELVIS W/CONTRAST	2,201.00	72196
34500223	MRI SPINE CERVICAL W/CONTRAST	3,984.00	72142
34500231	MRI SPINE CERVICAL W/O CONTRAS	2,914.00	72141
34500249	MRI SPINE CERVICAL W/WO CONTRA	5,270.00	72156
34500256	MRI SPINE LUMBAR W/CONTRAST	3,622.00	72149
34500264	MRI SPINE LUMBAR W/O CONTRAST	3,113.00	72148
34500272	MRI SPINE LUMBAR W/WO CONTRAST	4,796.00	72158
34500280	MRI SPINE THORACIC W/CONTRAST	4,035.00	72147
34500298	MRI SPINE THORACIC W/O CONTRAS	3,268.00	72146
34500306	MRI SPINE THORACIC W/WO CONTRA	4,433.00	72157
34500314	MRI TM JOINT	758.00	70336
34500322	MRI UPPER EXTREM ANY JOINT W/O	3,353.00	73221
34500330	MRI UPPER EXT,NOT JNT W/WO	3,399.00	73220
34500355	MRA PELVIS WITH & WITHOUT CONT	1,960.00	72198
34500363	MRA CHEST W/O CONTRAST	1,243.00	71555
34500371	INJECT PROC SHOULDER ARTH	845.00	23350
34500389	FLUOROSCOPY,SHOULDER INJ	291.00	77002
34500397	MRI SHOULDER W/O CONTRAST	3,353.00	73221
34500405	MR SPECTROSCOPY	1,162.00	76390
34500413	MRI BREAST UNI W/O CONTRAST	1,725.00	77058
34500421	MRI BREAST UNILAT W/CONTRAST	2,066.00	77058
34500439	MRI BREAST UNILAT W/WO CONT	2,934.00	77058
34500447	MRI BREAST BILAT WO CONTRAST	1,861.00	77059
34500454	MRI BREAST BILAT W/CONT	2,066.00	77059
34500462	MRI BREAST BILAT W/WO CONT	3,580.00	77059
34500470	MRA CHEST W/CONTRAST	1,243.00	71555
34500488	MRA CHEST W & WO CONTRAST	1,243.00	71555
34500496	MRA LOW EXT W/CONTRAST	2,203.00	73725
34500504	MRA LOW EXT W & WO CONTRAST	2,560.00	73725
34500512	MRA ABD W/CONTRAST	2,048.00	74185
34500520	MRA ABD W & WO CONTRAST	2,344.00	74185
34500595	UNLISTED MR PROCEDURE	617.00	76498
34500835	MRCP	2,453.00	74181
34500843	MRI SPINE CERVICAL W/O CONT LT	2,914.00	72141
34500850	MRI SPINE LUMBAR W/O CONT LT	3,113.00	72148
34500868	MRI SPINE THORACIC W/O CONT LT	3,268.00	72146
34500876	MRA PELVIS W CONTRAST	1,693.00	72198
34500884	MRA PELVIS W/O CONTRAST	1,434.00	72198
34500892	MRI EOVIST INJ PER ML	20.00	A9581

Charge Code	Description	Charge Amount	CPT / HCPCS Code
34500900	BREAST BX HANDPIECE	560.00	
34500918	BREAST BX OBTURATOR	318.00	
34500926	BREAST BX SITE MARKER	155.00	
34503649	MRI BX BRST 1ST LESION 19085	1,211.00	19085
34503656	MRI BX BRST ADD LESION 19086	575.00	19086
34505354	3D RENDER W/O POST PROCESS	429.00	76376
34505362	3D RENDER W/POST PROCESS	1,119.00	76377
34505388	MOD SEDATION <5 YRS 99143	524.00	99143
34505396	MOD SEDATION >5 YRS 99144	524.00	99144
34505768	MRA LOWER EXT W/O CONTRAST BIL	3,594.00	73725
34505784	MRI LOWER EXT ANY JNT W/O BIL	4,816.00	73721
34505792	MRI LOWER EXT NOT JNT W/WO BIL	5,977.00	73720
34505800	MRI UPPER EXT ANY JNT W/O BIL	3,353.00	73221
34505818	MRI UPPER EXT NOT JNT W/WO BIL	6,475.00	73220
34505826	MRI SHOULDER W/O CONTRAST BIL	3,353.00	73221
34505834	MRA LOWER EXT W CONTRAST BIL	4,194.00	73725
34505842	MRA LOWER EXT W&W/O CONT BIL	4,873.00	73725
34505859	MRI UPPER EXT NOT JNT W/O BIL	3,173.00	73218
34505867	MRI UPPER EXT NOT JNT W BIL	6,008.00	73219
34505875	MRI UPPER EXT ANY JNT W/BIL	6,702.00	73222
34505883	MRI UPPER EXT ANY JNT W/WO BIL	6,475.00	73223
34505891	MRI LOWER EXT NOT JNT W/O BIL	4,253.00	73718
34505909	MRI LOWER EXT NOT JNT W BIL	4,816.00	73719
34505917	MRI LOWER EXT ANY JNT W BIL	4,816.00	73722
34505925	MRI LOWER EXT ANY JNT W/WO BIL	5,977.00	73723
34505933	NEEDLE PLACEMENT MR GUIDANCE	1,245.00	77021
34505941	MRI CARD MORPH FUNC WO CONTRST	1,755.00	75557
34505966	MRI CARD STRSS IMAGE WO CONT	354.00	75559
34505982	MRI CARD MORPH FUNCT W CONTRST	573.00	75561
34506006	MRI CARD STRSS IMAGE W CONT	573.00	75563
34506014	CONS SEDATION EACH ADD 15 MINS	288.00	99145
34506071	BREAST,SURG SPECIMEN	85.00	76098
34506089	MRA SPINAL CANAL WO CONTRST	1,459.00	72159
34506097	MRA SPINAL CANAL W CONTRST	1,459.00	72159
34506105	MRA SPINAL CANAL WO/W CONTRST	1,459.00	72159
34506113	MRA UPPER EXT WO CONTRST	2,956.00	73225
34506121	MRA UPPER EXT W CONTRST	2,956.00	73225
34506139	MRA UPPER EXT WO/W CONTRST	2,956.00	73225
34506154	MRA UPPER EXT W CONTRST BIL	5,630.00	73225
34506162	MRA UPPER EXT WO/W CONTRST BIL	5,630.00	73225
34520007	MRI ORBIT,FACE/NECK W CONTRAST	3,450.00	70542
34520015	MRI ORBIT,FACE,NECK W/WO	4,472.00	70543
34520023	MRA HEAD W/O CONTRAST	2,049.00	70544
34520031	MRA HEAD W CONTRAST	3,031.00	70545
34520049	MRA HEAD W/WO CONTRAST	3,387.00	70546
34520056	MRA NECK W/O CONTRAST	2,049.00	70547
34520064	MRA NECK W CONTRAST	3,046.00	70548
34520072	MRA NECK W/WO CONTRAST	3,387.00	70549
34520080	MRI CHEST W CONTRAST	1,483.00	71551
34520098	MRI CHEST W & W/O CONTRAST	4,302.00	71552
34520106	MRA SPINAL CANAL W OR WO	1,459.00	72159

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Charge Code	Description	Charge Amount	CPT / HCPCS Code
34520114	MRI PELVIS W/O CONTRAST	1,493.00	72195
34520122	MRI PELVIS W & W/O CONTRAST	2,356.00	72197
34520130	MRI UPPER EXT,NOT JNT W/O	2,066.00	73218
34520148	MRI UPPER EXT,NOT JNT W	2,745.00	73219
34520155	MRI UPPER EXT ANY JNT W	3,065.00	73222
34520163	MRI UPPER EXT ANY JNT W/WO	3,399.00	73223
34520171	MRI LOWER EXT NOT JNT,WO	2,232.00	73718
34520189	MRI LOWER EXT NOT JNT,W	3,139.00	73719
34520197	MRI LOWER EXT ANY JNT W	3,139.00	73722
34520205	MRI LOWER EXT ANY JNT W/WO	3,498.00	73723
34520213	MRI ABDOMEN W	2,972.00	74182
34520221	MRI ABDOMEN W/WO	4,306.00	74183
34520288	FLUORO GUIDANCE FOR NEEDLE PLA	291.00	77002
34520296	MRI BONE MARROW BLOOD SUPPLY	1,717.00	77084

2. Identify the funding sources for this project.

a. Please check the applicable item(s) below and briefly summarize how the project will be financed. (Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)

___ A. Commercial loan -- Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions.

___ B. Tax - Exempt Bonds -- Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance.

___ C. General obligation bonds -- Copy of resolution from issuing authority or minutes from the appropriate meeting.

___ D. Grants -- Notification of intent form for grant application or notice of grant award.

___ E. Cash Reserves - Appropriate documentation from Chief Financial Officer.

_X_ F. Other - Identify and document funding from all other sources.

Response

The project will be funded through cash from operations. The CFO letter is attached.

1. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services And Development Agency.

SUPPLEMENTAL- 1

[redacted]

September 26, 2014
A – 11:40am

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY (d/b/a Erlanger Health System and Discretely Presented Component Units)

Audited Combined Financial Statements

Years Ended June 30, 2014 and 2013

PYA
Certified Public Accountants

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Audited Combined Financial Statements

Years Ended June 30, 2014 and 2013

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PERSHING YOAKLEY & ASSOCIATES
One Cherokee Mills, 2220 Sutherland Avenue
Knoxville, TN 37919
p: (865) 673-0844 | f: (865) 673-0173
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PYA
Certified Public Accountants

INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of
Chattanooga-Hamilton County Hospital Authority
(d/b/a Erlanger Health System):

Report on the Combined Financial Statements

We have audited the accompanying combined financial statements of the business-type activities of Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System (the Primary Health System) and its discretely presented component units, as of and for the years ended June 30, 2014 and 2013, and the related notes to the combined financial statements, which collectively comprise the Primary Health System's basic combined financial statements as listed in the table of contents.

Management's Responsibility for the Combined Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Primary Health System's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness

of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinions

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and the discretely presented component units of the Primary Health System as of June 30, 2014 and 2013, and the respective changes in financial position and, where applicable, cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note A to the combined financial statements, during the year ended June 30, 2014, the Primary Health System adopted a newly issued accounting standard that requires retroactive adjustments to amounts previously reported as of and for the year ended June 30, 2013, with a cumulative effect adjustment to net position as of June 30, 2012. Our opinion is not modified with respect to this matter.

Other Matters

Required Supplementary Information: Accounting principles generally accepted in the United States of America require that the management's discussion and analysis (shown on pages 3 through 11) be presented to supplement the basic combined financial statements. Such information, although not a part of the basic combined financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic combined financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic combined financial statements, and other knowledge we obtained during our audit of the basic combined financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Pershing Yoakley & Associates PC

Knoxville, Tennessee
September 17, 2014

Management's Discussion and Analysis

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Management's Discussion and Analysis

Years Ended June 30, 2014 and 2013

MANAGEMENT'S DISCUSSION AND ANALYSIS

The discussion and analysis of Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System's financial performance provides an overview of financial activities for the fiscal years ended June 30, 2014 and 2013.

Erlanger Health System (the Primary Health System) is the largest healthcare provider in Southeast Tennessee. The Primary Health System maintains a number of very specialized clinical services such as Level I trauma, Level III neonatal, kidney transplantation, a Regional Cancer Unit, a full service children's hospital, and open heart surgery, all of which are primarily serviced by four "Life Force" helicopters and supported by subspecialty physicians (residents, faculty and private attending physicians) located on its campuses.

OVERVIEW OF THE COMBINED FINANCIAL STATEMENTS

The combined financial statements consist of two parts: Management's Discussion and Analysis and the combined financial statements. The combined financial statements also include notes that explain in more detail some of the information in the combined financial statements.

The combined financial statements of the Primary Health System offer short-term and long-term financial information about its activities. The combined statements of net position include all of the Primary Health System's assets and liabilities and provide information about the nature and amounts of investments in resources (assets) and the obligations to the Primary Health System's creditors (liabilities). The assets and liabilities are presented in a classified format, which distinguishes between current and long-term assets and liabilities. It also provides the basis for computing rate of return, evaluating the capital structure of the Primary Health System and assessing the liquidity and financial flexibility of the Primary Health System.

All of the fiscal year's revenues and expenses are accounted for in the combined statements of revenue, expenses, and changes in net position. These statements measure the success of the Primary Health System's operations and can be used to determine whether the Primary Health System has successfully recovered all of its costs through the services provided, as well as its profitability and credit worthiness.

The final required financial statement is the combined statements of cash flows. The primary purpose of these statements is to provide information about the Primary Health System's cash receipts, cash payments and net changes in cash resulting from operating, investing, non-capital financing and financing activities. The statements also provide answers to such questions as where did cash come from, what was cash used for, and what was the change in the cash balance during the reporting period?

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Management's Discussion and Analysis - Continued

Years Ended June 30, 2014 and 2013

The analyses of the combined financial statements of the Primary Health System begins on the next page. One of the most important questions asked about the Primary Health System's finances is "Is the financial condition of the Primary Health System as a whole better or worse as a result of the fiscal year's activities?" The combined statements of net position and the combined statements of revenue, expenses and changes in net position report information about the Primary Health System's activities in a way that will help answer this question. These two statements report the net position of the Primary Health System and changes in the net position. One can think of the Primary Health System's net position – the difference between assets and liabilities – as one way to measure financial health or financial position. Over time, increases or decreases in the Primary Health System's net position is one indicator of whether its financial health is improving or deteriorating. However, one will need to consider other non-financial factors such as changes in economic conditions, regulations and new or changed government legislation.

REPORTING ENTITY

The Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System (the Primary Health System) was created by a private act passed by the General Assembly of the State of Tennessee on March 11, 1976, and adopted by a majority of the qualified voters of Hamilton County, Tennessee on August 5, 1976. The Primary Health System is considered the primary governmental unit for financial reporting purposes. As required by generally accepted accounting principles, these financial statements present the Primary Health System and its component units. The component units discussed below are included in the Primary Health System's reporting entity because of the significance of their operational, financial or other relationships with the Primary Health System.

ContinuCare HealthServices, Inc., Plaza Surgery, G.P., Cyberknife of Chattanooga, LLC (Cyberknife), UT-Erlanger Medical Group, Inc. (the Medical Group) and Erlanger Health Plan Trust are legally separate organizations for which the Primary Health System is either financially accountable or owns a majority interest. Accordingly, these organizations represent component units of the Primary Health System. The financial statements of Erlanger Health Plan Trust are blended with the financial statements of the Primary Health System, as the Board of Erlanger Health Plan Trust is substantially the same as that of the Primary Health System and the Primary Health System has operational responsibility.

During 2012, the Primary Health System acquired 100% ownership in Plaza Surgery, G.P. As a result, Plaza Surgery, G.P.'s operations are no longer distinct from the Primary Health System. During fiscal year 2011, Cyberknife was capitalized by contributions from the Primary Health System and certain other minority partners. Cyberknife provides radiation therapy services, specifically robotic stereotactic radiosurgical services through the use of a Cyberknife stereotactic radiosurgery system on the Primary Health System's campus. At June 30, 2014,

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Management's Discussion and Analysis - Continued

Years Ended June 30, 2014 and 2013

2013 and 2012, the Primary Health System owned 51% of Cyberknife's outstanding membership units. The Medical Group was formed on June 30, 2011 and will provide professional healthcare and related services to the public through its employed and contracted licensed physicians and other supporting healthcare providers. The Medical Group has no members; however, the Primary Health System may access the Medical Group's services. The Medical Group is currently not active.

KEY FINANCIAL INDICATORS

The following key financial indicators are for Erlanger Health System as a whole. They are inclusive of the Primary Health System, ContinuCare HealthServices, Inc., and the 51% controlling share of Cyberknife of Chattanooga, LLC.

- Excess revenues over expenses from operations for Erlanger Health System for the fiscal year 2014 is $18.0 million compared to excess expenses over revenues of $7.9 million for the fiscal year 2013 and excess expenses over revenues of $9.5 million for the fiscal year 2012.

- Total cash and investment reserves at June 30, 2014 are $139 million (excluding $31 million of funds held by Trustees or restricted by donors or others).

- Net days in accounts receivable for Erlanger Health System (utilizing a three month rolling average of net revenue) is 50 days at June 30, 2014 compared to 50 days at June 30, 2013 and 53 days at June 30, 2012.

- For fiscal year 2014, Erlanger Health System recognized $19.6 million in public hospital supplemental payments from the State of Tennessee.

- For fiscal year 2014, Erlanger Health System recognized $12.8 million in essential access payments from the State of Tennessee compare to $10.6 million in fiscal year 2013 and $11.4 million in fiscal year 2012.

- For fiscal year 2014, Erlanger Health System did not recognize disproportionate share payments from the State of Tennessee compared to $8.5 million in fiscal year 2013 and $9.2 million in fiscal year 2012.

- For fiscal year 2014, Erlanger Health System recognized $0.9 million in trauma fund payments from the State of Tennessee compared to $1.1 million in fiscal year 2013 and $1.0 million in fiscal year 2012.

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- For fiscal year 2012, Erlanger Health System recognized $3.3 million in a Medicare rural floor budget neutrality settlement payment.

The required bond covenants ratios for fiscal year 2014 compared to bond requirements are as follows:

		Master	*Bond Insurer Requirements*		
	June 30, 2014	*Trust Indenture*	*98 Series*	*00 Series*	*04 Series*
Debt service coverage ratio	2.40	1.10	1.10	1.35	1.35
Cushion ratio	7.30	N/A	1.50	N/A	N/A
Current ratio	2.57	N/A	1.50	1.50	1.50
Days cash on hand	87	N/A	N/A	65 days	65 days
Indebtedness ratio	48%	N/A	N/A	N/A	65%
Operating cash flow margin	8%	N/A	N/A	5%	5%

The trust indentures and related documents underlying the bonds contain certain covenants and restrictions. For fiscal year 2014, Erlanger Health System met all required debt covenants. For fiscal year 2013, Erlanger Health System failed to satisfy the debt service coverage ratio required by one of the bond insurers. As a result of the non-compliance, the Primary Health System obtained a waiver from the bond insurer.

NET POSITION

Erlanger Health System's net position for the combined Primary Health System and Aggregate Discretely Presented Component Units increased by approximately $14 million in fiscal year 2014. Our analysis focuses on the net position (Table 1) and changes in net position (Table 2) of the Primary Health System's operating activities. Discussion focuses on the Primary Health System and its blended component units.

Net position for the Primary Health System increased from $182 million as of June 30, 2013 to $195 million as of June 30, 2014. The current ratio (current assets divided by current liabilities) increased from 2.25 in 2013 to 2.52 in 2014 for the Primary Health System.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Management's Discussion and Analysis - Continued

Years Ended June 30, 2014 and 2013

Table 1- Net Position (in Millions)

	June 30, 2014		*June 30, 2013*		*June 30, 2012 (before GASB 65 adoption)*	
	Primary Health System	*Discretely Presented Component Units*	*Primary Health System*	*Discretely Presented Component Units*	*Primary Health System*	*Discretely Presented Component Units*
Current and other assets	$ 333	$ 12	$ 309	$ 12	$ 328	$ 12
Capital assets	149	9	161	10	158	10
Total assets	480	21	470	22	486	22
Deferred ouflows of resources	1	-	1	-	-	-
	$ 481	$ 21	$ 471	$ 22	$ 486	$ 22
Long-term debt outstanding	$ 159	$ 3	$ 170	$ 3	$ 177	$ 4
Other liabilities	123	3	114	4	109	4
Total liabilities	282	6	284	8	286	8
Deferred inflows of resources	4	-	4	-	-	-
	$ 286	$ 6	$ 289	$ 8	$ 286	$ 8
Net position						
Net investment in capital assets	$ 1	$ 5	$ 10	$ 6	$ -	$ 5
Restricted, expendable	2	-	2	-	2	-
Unrestricted	191	9	170	8	198	9
Total net position	$ 194	$ 14	$ 182	$ 14	$ 200	$ 14

Days in cash increased from 73 days as of June 30, 2013 to 88 days as of June 30, 2014 for the Primary Health System resulting from increased operating margins combined with a $19.6 million public hospital supplemental payment received from the State of Tennessee in fiscal year 2014. Days in cash decreased from 81 days as of June 30, 2012 to 73 days as of June 30, 2013 for the Primary Health System due to decreased operating margins combined with a $8 million receivable for funds drawn on a line of credit extended to Hutcheson Medical Center, Inc. in fiscal year 2013.

Days in net accounts receivable were 51 days as of June 30, 2014 and June 30, 2013. Days in net accounts receivable decreased from 55 days as of June 30, 2012 to 51 days as of June 30, 2013.

Capital assets for the Primary Health System were $149 million as of June 30, 2014. Additions for fiscal year 2014 totaled $14 million while $5 million of assets were retired. Depreciation expense was $26 million for the Primary Health System. Retirement of assets reduced accumulated depreciation by $5 million in fiscal year 2014. Construction in progress was $5 million as of June 30, 2014. Included in construction in progress are Erlanger East development costs of $2.5 million.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Management's Discussion and Analysis - Continued

Years Ended June 30, 2014 and 2013

Capital assets for the Primary Health System were $161 million as of June 30, 2013. Additions for fiscal year 2013 totaled $30 million while $4 million of assets were retired. Depreciation expense was $27 million for the Primary Health System. Retirement of assets reduced accumulated depreciation by $4 million in fiscal year 2013. Construction in progress was $9 million as of June 30, 2013. Included in construction in progress at June 30, 2013 are surgical suite expansion projects totaling $3.2 million

	Primary Health System		
	2014	*2013*	*2012*
Land and improvements	$ 26	$ 26	$ 25
Buildings	234	231	224
Equipment	377	367	351
Total	637	624	600
Less accumulated depreciation	(493)	(472)	(449)
Construction in progress	5	9	7
Net property, plant and equipment	$ 149	$ 161	$ 158

Long-term debt outstanding amounted to $159 million as of June 30, 2014 compared to $169 million as of June 30, 2013. The decrease in long-term debt reflects normal scheduled principal payments. Long-term debt outstanding amounted to $169 million as of June 30, 2013 compared to $177 million as of June 30, 2012. The decrease in long-term debt reflects normal scheduled principal payments.

Other liabilities for the Primary Health System were $123 million as of June 30, 2014, $119 million at June 30, 2013, compared to $108 million as of June 30, 2012.

CHANGES IN NET POSITION

The focus for Erlanger Health System's management team during fiscal year 2014 and 2013 was to increase the Primary Health System's volumes in a number of key product lines in a downturned economy, improve relationships with stakeholders, and improve operating efficiencies.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Management's Discussion and Analysis - Continued

Years Ended June 30, 2014 and 2013

Table 2- Changes in Net Position (in Millions)

	June 30, 2014		*June 30, 2013*		*June 30, 2012*	
	Primary Health System	*Discretely Presented Component Units*	*Primary Health System*	*Discretely Presented Component Units*	*Primary Health System*	*Discretely Presented Component Units*
Net patient revenue	$ 571	$ 11	$ 526	$ 12	$ 514	$ 12
Other revenue	21	17	19	16	22	16
Total revenue	592	28	545	28	536	28
Expenses:						
Salaries	305	14	298	13	300	13
Supplies and other expenses	126	10	113	11	116	11
Purchased services	117	3	114	3	104	3
Depreciation and amortization	26	1	27	1	26	1
Total expenses	574	28	552	28	546	28
Operating income revenues in excess of (less than) expenses	18	1	(7)	-	(10)	-
Nonoperating gains	2	-	-	-	4	-
Interest expense and other	(9)	-	(7)	-	(11)	-
Operating/capital contributions	1	-	-	-	-	-
Change in net position	$ 12	$ 1	$ (14)	$ -	$ (17)	$ -

Net patient service revenue for the Primary Health System increased from $526 million in fiscal year 2013 to $571 million in fiscal year 2014. Admissions for fiscal year 2014 increased by 4.8% when compared to fiscal year 2013, while surgical mix increased over the prior year by 1.8%. The Erlanger East emergency room generated 15,900 additional emergency room visits compared to prior year.

Net patient service revenue for the Primary Health System increased from $514 million in fiscal year 2012 to $526 million in fiscal year 2013. Admissions for fiscal year 2013 were comparable to fiscal year 2012, however, case mix increased over the prior year by 1.6%. The Erlanger East emergency room opened in March 2013 generating 6,100 additional emergency room visits compared to prior year.

Salaries for the Primary Health System increased from $298 million in fiscal year 2013 to $305 million in fiscal year 2014. Staffing was in concert with the increased volumes. Paid FTE's per adjusted occupied bed decreased from 5.40 in fiscal year 2013 to 5.13 in fiscal year 2014, however, salary cost for fiscal year 2014 per hour increased by 2.2 % over the prior year. Inclement weather in January 2014 and February 2014 resulted in increased overtime wages. Salaries for the Primary Health System decreased from $300 million in fiscal year 2012 to $298 million in fiscal year 2013. Paid FTE's per adjusted occupied bed decreased from 5.60 in fiscal year 2012 to 5.40 in fiscal year 2013.

Supplies and other expenses increased from $113 million for fiscal year 2013 to $126 million in fiscal year 2014. Supplies and drug costs trended with the volume increases. Supplies and drugs per adjusted admission for the Primary Health System decreased from $1,587 in fiscal year 2013 to $1,555 in fiscal year 2014. Supplies and other expenses decreased from $116 million for fiscal year 2012 to $113 million for fiscal year 2013. Supplies and drugs per adjusted admission for the Primary Health System decreased from $1,675 in fiscal year 2012 to $1,587 in fiscal year 2013.

Purchased Services increased from $114 million in fiscal year 2013 to $117 million in fiscal year 2014 due primarily to the outsourcing of food and environmental services. Purchased Services increased from $104 million in fiscal year 2012 to $114 million in fiscal year 2013 due to contracted service expenditures assumed with the purchase of Plaza Surgery's minority interest, fees associated with the third party operational assessment and implementation, and an increase in rent expense resulting from the sale of the Erlanger East POB.

Depreciation and amortization expense decreased from $27 million in fiscal year 2013 to $26 million in fiscal year 2014 due to decreased capital spending. Depreciation and amortization expense increased from $26 million in fiscal year 2012 to $27 million in fiscal year 2013 due, in part, to the addition of the Erlanger East emergency room.

Interest expense, including gain (or loss) on mark-to-market of interest rate swaps, increased from $7 million in fiscal year 2013 to $9 million in fiscal year 2014. The market value of the liability for the mark-to-market of interest rate swaps increased by $.9 million in fiscal year 2014 compared to an increase of $2.3 million in fiscal year 2013. Interest expense, including gain (or loss) on mark-to-market of interest rate swaps, decreased from $11 million in fiscal year 2012 to $7 million in fiscal year 2013. The market value of the liability for the mark-to-market of interest rate swaps increased by $2.3 million in fiscal year 2013 compared to a decrease of $1.1 million in fiscal year 2012.

OUTLOOK

The State of Tennessee continues to review the TennCare program (the State's Medicaid program). For fiscal years 2012 and 2013, the State passed a Hospital Coverage Fee to offset shortfalls in the State's budget for TennCare. The fee remained intact and TennCare rates were stable in fiscal year 2014. There could be possible TennCare rate changes in fiscal year 2015 as a result of rate variation initiatives. Out-of-state Medicaid and TennCare changes would affect the Primary Health System's bottom line with TennCare and Medicaid patients representing approximately 22% of the payer mix. Self Pay patients represent approximately 10% of the charge utilization. Healthcare reform and future changes in Medicare regulations could also have an adverse effect on the Primary Health System's future operations since Medicare represents approximately 33% of the payer mix.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Management's Discussion and Analysis - Continued

Years Ended June 30, 2014 and 2013

During fiscal year 2014, the Primary Health was added as a participant to the Public Hospital Supplemental Payment Pool for public hospitals in Tennessee through a collaborative effort with local Mayors, State Senators and Representatives, Hamilton County Medical Society, Board members, physicians and hospital leadership. The inclusion of the Primary Health System in the pool netted $19.6 million of additional federal funding for fiscal year 2014. The Primary Health System will receive this funding annually as long as the current TennCare waiver is intact.

The Primary Health System also secured a 5-year partnership agreement with BlueCross BlueShield of Tennessee (BCBST) to be the exclusive provider for new members under the health insurance exchange. BCBST is Tennessee's largest insurer and Chattanooga's largest provider. In addition to the exclusivity, the partnership included a $1M innovation grant and a combined marketing effort specifically aimed at major Chattanooga employers. The partnership provides for a more predictable, longer-term stable relationship with BCBST.

The Primary Health System recognized Essential Access payments totaling $12.8 million from the State of Tennessee for fiscal year 2014, an increase of $2.2 million from fiscal year 2013. Disproportionate share payments were not approved by Federal government for fiscal year 2014. The Primary Health System received Disproportionate Share Payments of $8.5 million in fiscal year 2013. The Primary Health System recognized Essential Access and Disproportionate Share payments totaling $19.1 million from the State of Tennessee for fiscal year 2013, a decrease of $1.5 million from fiscal year 2012. Additionally, the Primary Health System recognized trauma funding of $.9 million in fiscal year 2014 compared to $1.1 million in fiscal year 2013 and $1.0 million in fiscal year 2012. Payments from the State of Tennessee for the fiscal year 2015 are expected to be consistent with the fiscal year 2014. Due to the 1966 Hamilton County Sales Tax Agreement expiring in May 2011, the Hamilton County appropriations to the Primary Health System have been reduced from $3 million to $1.5 million for fiscal years 2014 and 2013.

Several initiatives continue to be underway to increase the Primary Health System's profitable position for the upcoming fiscal year. Operating improvements are being implemented to continue to reduce expenses and grow surgical volumes. Increased surgery volumes are essential to the financial health of the Primary Health System.

SUPPLEMENTAL- 1

September 26, 2014
11:40am

Audited Combined Financial Statements

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Net Position - Continued

	June 30, 2014	
	Primary Health System	*Discretely Presented Component Units*
CURRENT ASSETS:		
Cash and cash equivalents	$ 44,202,064	$ 765,461
Temporary investments	1,384,865	5,564,277
Assets limited as to use available for current liabilities	7	-
Patient accounts receivable, net	79,428,961	1,950,888
Estimated amounts due from third party payers	11,408,963	-
Due from other governments	126,882	369,250
Inventories	11,612,639	1,133,754
Receivable from Hutcheson Medical Center	20,550,000	-
Other current assets	14,091,719	1,391,485
TOTAL CURRENT ASSETS	182,806,100	11,175,115
NET PROPERTY, PLANT AND EQUIPMENT	148,545,204	9,005,633
LONG-TERM INVESTMENTS, for working capital	326,139	-
ASSETS LIMITED AS TO USE	131,928,433	-
OTHER ASSETS:		
Prepaid bond insurance	2,093,412	-
Equity in discretely presented component units and other	14,124,270	-
Other assets	437,820	946,676
TOTAL OTHER ASSETS	16,655,502	946,676
TOTAL ASSETS	480,261,378	21,127,424
DEFERRED OUTFLOWS OF RESOURCES		
Deferred amounts from debt refunding	723,313	-
ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 480,984,691	$ 21,127,424
CURRENT LIABILITIES:		
Accounts payable and accrued expenses	$ 41,948,260	$ 1,461,825
Accrued salaries and related liabilities	14,805,150	856,123
Estimated amounts due to third party payers	-	109,881
Due to other governments	369,250	126,882
Current portion of long-term debt and capital lease obligations	10,809,288	616,369
Other current liabilities	4,648,355	175,587
TOTAL CURRENT LIABILITIES	72,580,303	3,346,667
LONG-TERM DEBT AND CAPITAL LEASE OBLIGATIONS	159,321,067	3,143,710
PENSION AND POST-EMPLOYMENT BENEFIT OBLIGATIONS	26,680,336	-
OTHER LONG-TERM LIABILITIES	23,913,836	-
TOTAL LIABILITIES	282,495,542	6,490,377
DEFERRED INFLOWS OF RESOURCES		
Deferred gain from sale-leaseback	3,935,725	-
NET POSITION:		
Unrestricted	190,840,242	9,316,184
Net investment in capital assets	1,234,111	5,320,863
Restricted expendable	2,479,071	-
TOTAL NET POSITION	194,553,424	14,637,047
LIABILITES, DEFERRED OUTFLOWS OF RESOURCES AND NET POSITION	$ 480,984,691	$ 21,127,424

See notes to combined financial statements.

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CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Net Position - Continued

	June 30, 2013 (Restated)	
	Primary Health System	*Discretely Presented Component Units*
CURRENT ASSETS:		
Cash and cash equivalents	$ 17,250,905	$ 930,587
Temporary investments	13,797,542	2,938,131
Assets limited as to use available for current liabilities	28,275	-
Patient accounts receivable, net	73,561,669	2,408,177
Estimated amounts due from third party payers	3,116,389	-
Due from other governments	528,032	377,239
Inventories	11,861,728	1,161,097
Receivable from Hutcheson Medical Center	20,550,000	-
Other current assets	20,129,320	1,917,719
TOTAL CURRENT ASSETS	160,823,860	9,732,950
NET PROPERTY, PLANT AND EQUIPMENT	160,973,575	9,643,816
LONG-TERM INVESTMENTS, for working capital	1,790,946	1,599,946
ASSETS LIMITED AS TO USE	130,231,028	-
OTHER ASSETS:		
Prepaid bond insurance	2,367,769	-
Equity in discretely presented component units and other	13,639,860	-
Other assets	437,820	858,972
TOTAL OTHER ASSETS	16,445,449	858,972
TOTAL ASSETS	470,264,858	21,835,684
DEFERRED OUTFLOWS OF RESOURCES		
Deferred amounts from debt refunding	809,251	-
ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 471,074,109	$ 21,835,684
CURRENT LIABILITIES:		
Accounts payable and accrued expenses	$ 46,945,723	$ 1,425,315
Accrued salaries and related liabilities	14,015,721	910,318
Estimated amounts due to third party payers	-	93,625
Due to other governments	377,239	528,032
Current portion of long-term debt and capital lease obligations	8,058,625	556,698
Other current liabilities	2,194,117	838,223
TOTAL CURRENT LIABILITIES	71,591,425	4,352,211
LONG-TERM DEBT AND CAPITAL LEASE OBLIGATIONS	170,179,424	3,445,959
PENSION AND POST-EMPLOYMENT BENEFIT OBLIGATIONS	17,406,052	-
OTHER LONG-TERM LIABILITIES	25,100,226	-
TOTAL LIABILITIES	284,277,127	7,798,170
DEFERRED INFLOWS OF RESOURCES		
Deferred gain from sale-leaseback	4,400,481	-
NET POSITION:		
Unrestricted	170,051,736	8,321,046
Net investment in capital assets	10,125,742	5,716,468
Restricted expendable	2,219,023	-
TOTAL NET POSITION	182,396,501	14,037,514
LIABILITES, DEFERRED OUTFLOWS OF RESOURCES AND NET POSITION	$ 471,074,109	$ 21,835,684

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Revenue, Expenses and Changes in Net Position - Continued

	Year Ended June 30, 2014	
	Primary Health System	*Discretely Presented Component Units*
OPERATING REVENUE:		
Charges for services:		
Net patient service revenue	$ 571,264,197	$ 11,231,722
Other revenue	20,718,399	17,098,407
TOTAL OPERATING REVENUE	591,982,596	28,330,129
OPERATING EXPENSES:		
Salaries, wages and benefits	305,113,185	13,638,588
Supplies and other expenses	122,623,180	10,246,727
Purchased services	117,156,784	2,573,864
Insurance and taxes	2,988,771	379,274
Depreciation	26,182,683	1,109,747
TOTAL OPERATING EXPENSES	574,064,603	27,948,200
OPERATING INCOME	17,917,993	381,929
NONOPERATING REVENUE (EXPENSES):		
Gain on disposal of assets	371,296	18,496
Interest and investment income, net of fees	245,537	397,461
Net gain from discretely presented component units and other	484,410	-
Interest expense	(8,559,590)	(181,803)
Provision for income taxes	-	(16,550)
Change in mark-to-market of interest rate swaps	873,783	-
NET NONOPERATING REVENUE (EXPENSES)	(6,584,564)	217,604
INCOME BEFORE CONTRIBUTIONS	11,333,429	599,533
Operating contributions	382,825	-
Capital contributions	440,669	-
CHANGE IN NET POSITION	12,156,923	599,533
NET POSITION AT BEGINNING OF YEAR	182,396,501	14,037,514
NET POSITION AT END OF YEAR	$ 194,553,424	$ 14,637,047

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Revenue, Expenses and Changes in Net Position - Continued

	Year Ended June 30, 2013 (Restated)	
	Primary Health System	*Discretely Presented Component Units*
OPERATING REVENUE:		
Charges for services:		
Net patient service revenue	$ 526,139,300	$ 11,345,856
Other revenue	18,969,187	16,241,907
TOTAL OPERATING REVENUE	545,108,487	27,587,763
OPERATING EXPENSES:		
Salaries, wages and benefits	297,831,739	13,607,440
Supplies and other expenses	110,970,317	10,199,559
Purchased services	114,011,044	2,981,048
Insurance and taxes	2,476,434	295,336
Depreciation	26,856,073	1,045,235
TOTAL OPERATING EXPENSES	552,145,607	28,128,618
OPERATING LOSS	(7,037,120)	(540,855)
NONOPERATING REVENUE (EXPENSES):		
Gain on disposal of assets	244,660	590,326
Interest and investment income, net of fees	24,827	104,642
Net loss from discretely presented component units and other	(261,887)	(175,000)
Interest expense	(9,190,977)	(208,669)
Provision for income taxes	-	(8,663)
Change in mark-to-market of interest rate swaps	2,256,035	-
NET NONOPERATING REVENUE (EXPENSES)	(6,927,342)	302,636
LOSS BEFORE CONTRIBUTIONS	(13,964,462)	(238,219)
Operating distributions	7,248	-
Capital contributions/other, net	220,977	-
CHANGE IN NET POSITION	(13,736,237)	(238,219)
NET POSITION AT BEGINNING OF YEAR, as previously reported	199,949,930	14,275,733
CUMULATIVE EFFECT OF CHANGE IN ACCOUNTING PRINCIPLE	(3,817,192)	-
NET POSITION AT BEGINNING OF YEAR	196,132,738	14,275,733
NET POSITION AT END OF YEAR	$ 182,396,501	$ 14,037,514

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Cash Flows - Continued

	Primary Health System Year Ended June 30,	
	2014	*2013*
CASH FLOWS FROM OPERATING ACTIVITIES:		
Receipts from third-party payers and patients	$ 561,765,342	$ 527,371,215
Payments to vendors and others for supplies, purchased services, and other expenses	(245,573,098)	(217,039,131)
Payments to and on behalf of employees	(295,049,472)	(297,118,972)
Other receipts	22,685,770	23,375,977
NET CASH PROVIDED BY OPERATING ACTIVITIES	43,828,542	36,589,089
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES:		
Contributions	382,825	7,248
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Acquisition and construction of capital assets, net	(13,929,432)	(30,339,955)
Principal paid on bonds, capital lease obligations and other	(8,048,272)	(7,900,842)
Proceeds from sale of assets	81,660	473,130
Interest payments on long-term debt	(8,258,717)	(8,971,728)
Capital contributions	440,669	220,977
NET CASH USED IN CAPITAL AND RELATED FINANCING ACTIVITIES	(29,714,092)	(46,518,418)
CASH FLOWS FROM INVESTING ACTIVITIES:		
Interest, dividends, and net realized gains (losses) on investments	245,537	2,468,950
Change in temporary and long-term investments for working capital	13,877,484	(815,435)
Advances under note agreeements	-	(8,050,000)
Net cash provided by (transferred to) assets limited as to use	(1,669,137)	5,749,002
NET CASH (USED IN) PROVIDED BY INVESTING ACTIVITIES	12,453,884	(647,483)
INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	26,951,159	(10,569,564)
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR	17,250,905	27,820,469
CASH AND CASH EQUIVALENTS AT END OF YEAR	$ 44,202,064	$ 17,250,905

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Cash Flows - Continued

	Primary Health System Year Ended June 30,	
	2014	*2013*
RECONCILIATION OF OPERATING INCOME (LOSS) TO NET CASH PROVIDED BY OPERATING ACTIVITIES:		
Operating income (loss)	$ 17,917,993	$ (7,037,120)
Adjustments to reconcile operating loss to net cash provided by operating activities:		
Depreciation	26,182,683	26,856,073
Amortization of other liabilities	(393,607)	(620,506)
Changes in assets and liabilities:		
Patient accounts receivable, net	(5,867,292)	3,079,769
Estimated amounts due from third party payers, net	(8,292,574)	(3,497,287)
Inventories and other assets	6,687,840	6,261,212
Accounts payable and accrued expenses	(4,916,463)	10,187,021
Accrued salaries and related liabilities	789,429	(135,013)
Other current and long-term liabilities	11,720,533	1,494,940
NET CASH PROVIDED BY OPERATING ACTIVITIES	$ 43,828,542	$ 36,589,089

SUPPLEMENTAL INFORMATION:

During the year ended June 30, 2013, The Primary Health System received a commitment from a third party to reimburse the Primary Health System for $1,900,000 in renovations performed at Erlanger East. The Primary Health System also recorded a liability in the amount of $1,900,000 that will be amortized (and recognized as operating revenue) over the lease term of 20 years.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Notes to Combined Financial Statements

Years Ended June 30, 2014 and 2013

NOTE A--SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity: The Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System (the Primary Health System) was created by a private act passed by the General Assembly of the State of Tennessee on March 11, 1976, and adopted by a majority of the qualified voters of Hamilton County, Tennessee on August 5, 1976. The Chattanooga-Hamilton County Hospital Authority consists of the Primary Health System and its aggregate discretely presented component units as disclosed below.

The Primary Health System provides comprehensive healthcare services throughout Hamilton and Bledsoe counties, as well as outlying areas in southeastern Tennessee and north Georgia. These services are provided primarily through the hospital and other facilities located on the Baroness campus of Erlanger Medical Center. The Primary Health System also operates other hospitals and clinics throughout the area. The Primary Health System is considered the primary governmental unit for financial reporting purposes. As required by accounting principles generally accepted in the United States of America, these combined financial statements present the Primary Health System and its component units. The component units discussed below are included in the Primary Health System's reporting entity because of the significance of their operational or financial relationships with the Primary Health System.

The primary mission of the Primary Health System and its component units is to provide healthcare services to the citizens of Chattanooga, Hamilton County and the surrounding area. Only those activities directly associated with this purpose are considered to be operating activities. Other activities that result in gains or losses unrelated to the Primary Health System's primary mission are considered to be nonoperating.

Erlanger Health Plan Trust, Plaza Surgery, G.P., ContinuCare HealthServices, Inc., Cyberknife of Chattanooga, LLC, and UT-Erlanger Medical Group, Inc. are legally separate organizations which the Primary Health System has determined are component units of the Primary Health System.

Blended Component Units: The financial statements of Erlanger Health Plan Trust include assets limited as to use totaling $1,627,033 and $1,619,834 as of June 30, 2014 and 2013, respectively, and net investment income totaling $7,199 and $9,987 for the years ended June 30, 2014 and 2013, respectively, that are blended in the combined financial statements of the Primary Health System. The board of the Erlanger Health Plan Trust is substantially the same as that of the Primary Health System and the Primary Health System has operational responsibility.

Plaza Surgery, G.P. (Plaza) was a joint venture which operated an ambulatory surgery center on the Primary Health System's campus. In 2012, the Primary Health System purchased all the remaining outstanding units of Plaza and its operations were transferred to the Primary Health

System, although Plaza remains a separate legal entity. Plaza had no assets, liabilities or operations in 2014 or 2013.

Discretely Presented Component Units: The discretely presented component units column in the combined financial statements includes the financial data of the Primary Health System's other component units. They are reported in a separate column to emphasize that they are legally separate from the Primary Health System. See the combined, condensed financial information in Note Q.

1. ContinuCare HealthServices, Inc. and subsidiary (ContinuCare) provide health and supportive services to individuals in their homes in the Hamilton County and north Georgia areas. ContinuCare also provides retail pharmacy goods and services at four locations in Hamilton County. The Primary Health System owns 100% of the stock of ContinuCare. Separately audited financial statements for ContinuCare HealthServices, Inc. may be obtained by mailing a request to 1501 Riverside Drive, Suite 140, Chattanooga, Tennessee 37406.

2. Cyberknife of Chattanooga, LLC (Cyberknife) provides radiation therapy services, specifically robotic stereotactic radiosurgical services, through the use of a cyberknife stereotactic radiosurgery system on the Primary Health System's campus. At June 30, 2014 and 2013 the Primary Health System owns 51% of Cyberknife's outstanding membership units and Cyberknife is fiscally dependent on the Primary Health System.

   A condition of admission as a Member of Cyberknife, is to deliver limited guaranties, guaranteeing prorata repayment of indebtedness of Cyberknife incurred to finance its equipment costs and its working capital needs. As of June 30, 2014 and 2013, total debt outstanding was $3,679,502 and $3,916,667, respectively, with payments due through 2016. Management believes that the Primary Health System will not be required to make any payments related to the guarantee of this indebtedness.

3. UT-Erlanger Medical Group, Inc. (the Medical Group) was formed on June 30, 2011 and will provide professional healthcare and related services to the public through employed and contracted licensed physicians and other supporting healthcare providers. The Medical Group has no members; however, the Primary Health System may access the Medical Group's services. The Primary Health System is not entitled to any potential earnings of the Medical Group except for compensation for services rendered to the Medical group on its behalf. However, based upon the significance of the Medical Group's potential operation to the Primary Health System, management believes its exclusion would be misleading and as such, includes the Medical Group as a component unit. The Medical Group is currently not active.

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Erlanger Health System Foundations (the Foundation): The Foundation assists the Primary Health System to promote and develop charitable and educational opportunities as they relate to healthcare services provided by the Primary Health System. The Primary Health System is not financially accountable for the Foundation and as a result the Foundation has not been included in the combined financial statements.

Contributions from the Foundation totaling approximately $1,170,000 and $920,000 for the years ended June 30, 2014 and 2013, respectively, were recognized as contribution revenue by the Primary Health System. The Primary Health System provided support to the Foundation of $730,000 in 2014 and $347,000 in 2013.

Use of Estimates: The preparation of the combined financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the combined financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Enterprise Fund Accounting: The Primary Health System and its blended component units utilize the enterprise fund method of accounting whereby revenue and expenses are recognized on the accrual basis using the economic resources measurement focus.

Recently Issued or Effective Accounting Pronouncements: In June 2011, the Governmental Accounting Standards Board (GASB) issued Statement No. 63, *Financial Reporting of Deferred Outflows of Resources, Deferred Inflows of Resources, and Net Position.* This Statement amends the net asset reporting requirements of GASB Statement No. 34 and other pronouncements by incorporating deferred outflows and inflows of resources into the definitions of the required components of the residual measure and renaming that measure as net position, rather than net assets. The requirements of this Statement were adopted by the Primary Health System in fiscal year 2013 and the adoption did not have a material impact on the combined financial statements.

In March 2012, the GASB issued Statement No. 65, *Items Previously Reported as Assets and Liabilities.* Statement No. 65 establishes reporting standards that reclassify items previously reported as assets or liabilities as deferred inflows or outflows and was adopted by the Primary Health System in 2014. GASB Statement No. 65 further requires that costs associated with the issuance of long-term debt, other than insurance costs, be expensed in the period incurred, rather than deferred and amortized over the term of the related debt. As a result of the retroactive application of this guidance, certain amounts previously reported as of and for the year ended June 30, 2013, have been restated and a cumulative effect adjustment has been recorded to the net position as of June 30, 2012. The effect of this application on previously reported combined financial statement amounts for the Primary Health System reduced deferred financing cost

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reported at June 30, 2013 by $3,466,006 and reduced interest expense for the year ended June 30, 2013 by $351,186.

Further, GASB 65 requires certain amounts previously reported as assets or liabilities be reclassified as deferred outflows or inflows. Such items include the unrecognized gain on a sale-leaseback transaction and losses on previously refunded debt. The 2013 combined financial statements have been reclassified to conform with these provisions of Statement No. 65.

In June 2012, the GASB issued Statement No. 68, *Accounting and Financial Reporting for Pensions*. Statement No. 68 provides guidance for improved accounting and financial reporting by state and local government entities related to pensions. It also replaces the requirements of GASB Statement No. 27 and Statement No. 50, as they relate to pensions that are provided through pension plans administered as trusts or equivalent arrangements that meet certain criteria. Additionally, the GASB issued Statement No. 71, *Pension Transition for Contributions Made Subsequent to the Management Date*, which is effective concurrent with Statement No. 68. Among other requirements, the Primary Health System will have to record a net pension liability that is based on fiduciary plan net position rather than on plan funding an provide explanatory disclosures in the notes to the financial statements. These Statements are required for fiscal years beginning after June 15, 2014 with early adoption encouraged. These Statements will be effective for the Primary Health System in 2015 and management and its actuaries are currently evaluating its impact on the combined financial statements.

Net Patient Service Revenue/Receivables: Net patient service revenue is reported on the accrual basis in the period in which services are provided at rates which reflect the amount expected to be collected. Net patient service revenue includes amounts estimated by management to be reimbursable by third-party payer programs under payment formulas in effect. Net patient revenue also includes an estimated provision for bad debts based upon management's evaluation of collectability based upon the age of the receivables and other criteria, such as payer classification and management's assumptions about conditions it expects to exist and courses of action it expects to take. The Primary Health System's policies do not require collateral or other security for accounts receivable, although the Primary Health System routinely accepts assignment or is otherwise entitled to receive patient benefits payable under health insurance programs, plans or policies. Supplemental payments from the State of Tennessee are recognized when determinable (see Note B).

Charity Care: The Primary Health System accepts patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain policies established by the County Auditor with regard to the Hamilton County indigent program or by the Primary Health System for other patients. Essentially, these policies define charity services as those services for which minimal payment is anticipated. In assessing a patient's inability to pay, the County and the Primary Health System utilize the generally recognized poverty income levels, but also include

certain cases where incurred charges are significant when compared to the income of the patient. These charges are not included in net patient service revenue.

Cash Equivalents: The Primary Health System considers all highly liquid investments with maturities of three months or less when purchased, excluding amounts whose use is limited by board designation, held by trustees under indenture agreement, or otherwise restricted as to use, to be cash equivalents.

Inventories: Inventories consist principally of medical and surgical supplies, general store supplies, and pharmacy items and are stated at lower of cost (first-in, first-out) or fair market value.

Investments: The Primary Health System's investments (including assets limited as to use) are reported at fair market value based on quoted market prices. Assets limited as to use include funds designated by the Board, funds held by trustees under trust indentures, and funds restricted by donors or grantors for specific purposes. The Primary Health System considers those investments with maturities of more than three months when purchased, maturing in more than one year and whose use is not limited by board designation, held by trustees under indenture agreement, or otherwise restricted as to use, to be long-term investments. Investments, including assets limited as to use, consist of United States government, government agency and municipal bonds, corporate debt and other short-term investments.

Temporary Investments: The Primary Health System considers all highly liquid investments with maturities of more than three months when purchased and maturing in less than one year, excluding amounts whose use is limited by board designation, held by trustees under indenture agreement, or otherwise restricted as to use, to be temporary investments. Temporary investments consist primarily of United States government agency bonds, municipal bonds and commercial paper.

Derivative Instruments: The Primary Health System records all derivatives as assets or liabilities on the combined statements of net position at estimated fair value and includes credit value adjustments. The Primary Health System's derivative holdings consist of interest rate swap agreements. Since these derivatives have not been determined to be effective, the gain or loss resulting from changes in the fair value of the derivatives is recognized in the accompanying combined statements of revenue, expenses and changes in net position. The Primary Health System's objectives in using derivatives are to take advantage of the differences between taxable and tax-exempt debt, and manage exposure to interest rate risks associated with various debt instruments (see Note N).

Net Property, Plant and Equipment: Property, plant and equipment is recorded on the basis of cost. Donated assets are recorded at their fair market value at the date of donation. Leases that

are substantially installment purchases of property are recorded as assets and amortized over their estimated useful lives ranging from three to thirty years; related amortization is included in depreciation expense. Depreciation expense is computed over estimated service lives of the respective classes of assets using the straight-line method. The Primary Health System has established a capitalization threshold for property, plant and equipment of $2,500 except for computer equipment, which has a threshold of $1,000. Interest expense and interest income on borrowed funds related to construction projects are capitalized during the construction period, if material. Costs of maintenance and repairs are charged to expense as incurred.

The Primary Health System reviews the carrying value of capital assets if facts and circumstances indicate that recoverability may be impaired. A capital asset is considered impaired when its service utility has declined significantly and unexpectedly. The Primary Health System did not experience any prominent events or changes in circumstances affecting capital assets which would require determination as to whether impairment of a capital asset has occurred during the years ended June 30, 2014 and 2013.

Compensated Absences: The Primary Health System recognizes an expense and accrues a liability for employees' paid annual leave and short-term disability in the period in which the employees' right to such compensated absences are earned. Liabilities expected to be paid within one year are included as accrued salaries and related liabilities in the accompanying combined statements of net position.

Prepaid Bond Insurance: Deferred financing costs consist of insurance costs associated with bond issues and are being amortized, generally, over the terms of the respective debt issues by the effective interest method.

Income Taxes: The Primary Health System is exempt from income taxes under Section 501(a) as an organization described in Section 501(c)(3) of the Internal Revenue Code (IRC). In addition, it qualifies for exemption from federal income taxes pursuant to IRC Section 115 as an instrumentality of the State of Tennessee. Therefore, no provision for income taxes has been recognized in the accompanying combined financial statements for the Primary Health System. Certain tax returns that are required for the years ended June 30, 2010 through 2013 are subject to examination by taxing authorities.

As a for-profit entity, ContinuCare is subject to state and federal income taxes. ContinuCare HealthServices, Inc. and its subsidiary file consolidated federal income tax returns separately from the Primary Health System. At June 30, 2014 and 2013, ContinuCare had no significant uncertain tax positions. Tax returns for the years ended June 30, 2008 through 2013 are subject to examination by taxing authorities.

As a Limited Liability Corporation, Cyberknife, a discretely presented component unit, is subject to State of Tennessee income taxes. At June 30, 2014 and 2013, Cyberknife had no significant uncertain tax positions. Tax returns for the years ended June 30, 2010 through 2013 are subject to examination by taxing authorities.

Contributed Resources: Resources restricted by donors for specific operating purposes are held as restricted funds and are recognized as operating or capital contributions in the accompanying combined financial statements. When expended for the intended purpose, they are reported as operating distributions and are recognized as other operating revenue. Contributed resources consist of amounts restricted by donors for specific purposes. Fundraising expenses are netted against contributions recognized.

Net Position: The net position of the Primary Health System is classified into three components. *Net investment in capital assets* consists of capital and other assets net of accumulated depreciation and reduced by the current balances of any outstanding borrowings used to finance the purchase or construction of those assets. The *restricted expendable* net position consists of assets that must be used for a particular purpose that are either externally imposed by creditors, grantors, contributors or laws or regulations of other governments or imposed by law through constitutional provisions or enabling legislation. *The unrestricted net position* is remaining assets that do not meet the definition of *net investment in capital assets* or *restricted expendable.*

Fair Value of Financial Instruments: The carrying amounts reported in the combined statements of net position for cash, accounts receivable, investments, accounts payable and accrued expenses approximate fair value.

The carrying value of long-term debt and capital lease obligations (including the current portion) was $170,130,355 as of June 30, 2014 and $178,238,049 as of June 30, 2013. The estimated fair value of long-term debt and capital lease obligations (including current portion) was $175,879,323 and $186,227,537 as of June 30, 2014 and 2013, respectively. The fair value of long-term debt related to fixed interest long-term debt and capital lease obligations was estimated using discounted cash flows, based on the Primary Health System's incremental borrowing rates or from quotes obtained from investment advisors. The fair value of long-term debt related to variable rate debt approximates its carrying value.

Subsequent Events: The Primary Health System evaluated all events or transactions that occurred after June 30, 2014 through September 17, 2014 , the date the combined financial statements were available to be issued.

Reclassifications: In addition to the adoption of GASB Statement 65, discussed previously, certain reclassifications have been made to the 2013 combined financial statements to conform with the 2014 combined financial statement presentation.

NOTE B--NET PATIENT SERVICE REVENUE

A reconciliation of the amount of services provided to patients at established rates by the Primary Health System to net patient service revenue as presented in the combined statements of revenue, expenses and changes in net position for the years ended June 30, 2014 and 2013 is as follows:

	Primary Health System	
	2014	*2013*
Inpatient service charges	$ 1,053,446,232	$ 986,725,639
Outpatient service charges	810,507,858	706,628,068
Gross patient service charges	1,863,954,090	1,693,353,707
Less: Contractual adjustments and other discounts	1,099,744,626	991,945,605
Charity care	109,777,939	101,729,252
Estimated provision for bad debts	83,167,328	73,539,550
	1,292,689,893	1,167,214,407
Net patient service revenue	$ 571,264,197	$ 526,139,300

Charity Care and Community Benefit: The Private Act of the State of Tennessee establishing the Primary Health System obligates the Primary Health System to make its facilities and patient care programs available to the indigent residents of Hamilton County to the extent of funds appropriated by Hamilton County and adjusted operating profits, as defined. The annual appropriation from Hamilton County totaled $1,500,000 for fiscal year 2014 and 2013. Total charity care charges for services provided to the certified indigent residents of Hamilton County (net of the appropriation) were approximately $19,336,000 and $23,757,000 for the years ended June 30, 2014 and 2013 for the Primary Health System.

In addition to charity care provided to specific patients within the hospital setting, the Primary Health System also provides unreimbursed services to the community which includes free and low cost health screenings. The Primary Health System also hosts health fairs and helps sponsor many other events that are free to the public and are spread throughout the year in various community locations.

The Primary Health System's Community Relations department, which conducts health, wellness, safety education classes and health screenings, includes Erlanger HealthLink Plus, a free adult membership program with over 15,000 members in the Chattanooga Statistical Metropolitan Service Area. The program provides over 16 classes and/or screenings and fitness opportunities per month that are free or at a low cost to members and to the community. These classes and screenings are held in two primary locations with additional classes at satellite locations in the region. As part of Community Relations, Safe & Sound, an injury prevention

service of Children's Hospital, offers free educational events regarding childhood injury prevention, including free car seat inspection and installation workshops. The Community Relations program utilizes the services of physicians, nurses, volunteers, educators, registered dietitians, social workers, secretaries and management personnel of the Primary Health System. The Primary Health System's consumer call center, Erlanger HealthLink (423-778-LINK) is a free call center staffed by RN's to answer health questions, offer free physician referrals and to register participants in the programs offered by Community Relations, Women's & Infant Services and other departments and divisions of the Primary Health System.

Uncompensated Care Costs: The following table summarizes the estimated total uncompensated care costs provided by Erlanger Medical Center as defined by the State of Tennessee for the years ended June 30, 2014 and 2013:

	2014	*2013*
Uncompensated cost of TennCare/Medicaid	$ 27,610,055	$ 28,228,719
Traditional charity uncompensated costs	33,421,647	33,423,115
Bad debt cost	25,128,811	23,429,117
Total estimated uncompensated care costs	$ 86,160,513	$ 85,080,951

The uncompensated cost of TennCare/Medicaid is estimated by taking the estimated cost of providing care to the TennCare/Medicaid patients less payments from the TennCare and Medicaid programs. The payments exclude revenues from essential access and other, one-time supplemental payments from TennCare of approximately $12,756,000 and $10,615,000 for the years ended June 30, 2014 and 2013, respectively, as such payments are not guaranteed for future periods.

Revenue from Significant Payers: Gross patient service charges related to the Medicare program accounted for approximately 32.7% and 29.6% of the Primary Health System's patient service charges for the years ended June 30, 2014 and 2013, respectively. Gross patient service charges related to the TennCare/Medicaid programs accounted for approximately 21.6% and 24.1% of the Primary Health System's patient service charges for the years ending June 30, 2014 and 2013, respectively. TennCare typically reimburses providers at an amount less than their cost of providing services to TennCare patients. At June 30, 2014 and 2013, the Primary Health System has a credit concentration related to the Medicare and TennCare programs.

During 2014 and 2013, the Primary Health System recognized revenue from these programs related to disproportionate share payments and trauma fund payments of approximately $926,000 and $9,622,000, respectively. Such amounts are subject to audit and future distributions under these programs are not guaranteed. Additionally, in 2014 the Primary Health System received a

net payment of $19,587,000 from the Public Hospital Supplemental Payment Pool. Such amounts are expected to be received as long as the current TennCare waiver is intact.

Laws and regulations governing the Medicare and TennCare/Medicaid programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates, as they relate to revenue recognized from these programs, will change by a material amount in the near term. The estimated reimbursement amounts are adjusted in subsequent periods as cost reports are prepared and filed and as final settlements are determined. Final determination of amounts earned under prospective payment and cost reimbursement activities is subject to review by appropriate governmental authorities or their agents. Management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under Medicare and Medicaid programs. The effect of prior year cost report settlements, or changes in estimates, increased net patient service revenue by approximately $2,310,000 in 2014 and by approximately $2,163,000 in 2013.

The Primary Health System has also entered into reimbursement agreements with certain commercial insurance companies, health maintenance organizations and preferred provider organizations. The basis for reimbursement under these agreements includes prospectively determined rates, per diems and discounts from established charges.

NOTE C--CASH AND CASH EQUIVALENTS

Cash and cash equivalents reported on the combined statements of net position include cash on hand and deposits with financial institutions including demand deposits and certificates of deposit.

The carrying amount of cash and cash equivalents consists of the following at June 30:

	Primary Health System	
	2014	*2013*
Demand deposits	$ 42,001,383	$ 15,087,535
Cash on hand	9,979	9,904
Cash equivalents	2,190,702	2,153,466
	$ 44,202,064	$ 17,250,905

Cash equivalents include money market accounts that are held in investment accounts and meet the definition of a cash equivalent.

Bank balances consist of the following at June 30:

	Primary Health System	
	2014	*2013*
Insured (FDIC)	$ 583,952	$ 622,493
Collateralized under the State of Tennessee Bank Collateral Pool	42,479,795	21,221,755
Other	-	272,275
	$ 43,063,747	$ 22,116,523

The Primary Health System's deposits would be exposed to custodial credit risk if they are not covered by depository insurance and the deposits are uncollateralized or are collateralized with securities held by the pledging financial institution's trust department or agent but not in the depositor government's name. The risk is that, in the event of the failure of a depository financial institution, the Primary Health System will not be able to recover deposits or will not be able to recover collateral securities that are in the possession of an outside party.

NOTE D--DISAGGREGATION OF RECEIVABLE AND PAYABLE BALANCES

Patient Accounts Receivable, Net: Patient accounts receivable and related allowances are as follows at June 30:

	Primary Health System	
	2014	*2013*
Gross patient accounts receivable	$ 302,865,848	$ 270,824,481
Estimated allowances for contractual adjustments and uncollectible accounts	(223,436,887)	(197,262,812)
Net patient accounts receivable	$ 79,428,961	$ 73,561,669

Other Current Assets: Other current assets consist of the following at June 30:

	Primary Health System	
	2014	*2013*
Prepaid expenses	$ 5,662,522	$ 5,205,938
Other receivables	8,429,197	14,923,382
Total other current assets	$ 14,091,719	$ 20,129,320

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
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Notes to Combined Financial Statements - Continued

Years Ended June 30, 2014 and 2013

Accounts Payable and Accrued Expenses: Accounts payable and accrued expenses consist of the following at June 30:

	Primary Health System	
	2014	*2013*
Due to vendors	$ 39,008,464	$ 44,847,075
Other	2,939,796	2,098,648
Total accounts payable and accrued expenses	$ 41,948,260	$ 46,945,723

Other Long-Term Liabilities: Other long-term liabilities, and the related activity, consist of the following at June 30:

	Balance at Beginning of Year	*Unearned Revenue*	*Unearned Revenue Recognized*	*Change in Estimate*	*Other*	*Balance at End of Year*
2014						
Compensated absences	$ 10,638,408	$ -	$ -	$ -	$ -	$ 10,638,408
Medical malpractice	4,985,000	-	-	81,000	-	5,066,000
Job injury program	1,253,139	-	-	-	-	1,253,139
Interest rate swaps	4,856,429	-	-	-	(873,783)	3,982,646
Other	3,367,250	-	(393,607)	-	-	2,973,643
Total other long-term liabilities	$ 25,100,226	$ -	$ (393,607)	$ 81,000	$ (873,783)	$ 23,913,836
2013						
Compensated absences	$ 10,638,408	$ -	$ -	$ -	$ -	$ 10,638,408
Medical malpractice	5,462,500	-	-	(477,500)	-	4,985,000
Job injury program	916,104	-	-	337,035	-	1,253,139
Interest rate swaps	7,112,464	-	-	-	(2,256,035)	4,856,429
Other	623,000	2,900,000	(155,750)	-	-	3,367,250
Total other long-term liabilities	$ 24,752,476	$ 2,900,000	$ (155,750)	$ (140,465)	$ (2,256,035)	$ 25,100,226

NOTE E--NET PROPERTY, PLANT AND EQUIPMENT

Net property, plant and equipment activity for the Primary Health System for the years ended June 30, 2014 and 2013 consisted of the following:

	Balance at June 30, 2012	*Additions*	*Reductions/ Transfers*	*Balance at June 30, 2013*	*Additions*	*Reductions/ Transfers*	*Balance at June 30, 2014*
Capital assets:							
Land and improvements	$ 25,355,906	$ 298,962	$ -	$ 25,654,868	$ 312,049	$ -	$ 25,966,917
Buildings	223,875,935	6,845,858	-	230,721,793	2,900,701	-	233,622,494
Equipment	350,516,661	20,581,177	(4,240,082)	366,857,756	14,813,614	(4,980,876)	376,690,494
	599,748,502	27,725,997	(4,240,082)	623,234,417	18,026,364	(4,980,876)	636,279,905

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
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Notes to Combined Financial Statements - Continued

Years Ended June 30, 2014 and 2013

	Balance at June 30, 2012	*Additions*	*Reductions/ Transfers*	*Balance at June 30, 2013*	*Additions*	*Reductions/ Transfers*	*Balance at June 30, 2014*
Accumulated depreciation :							
Land and improvements	(11,225,230)	(398,356)	-	(11,623,586)	(449,132)	-	(12,072,718)
Buildings	(161,792,780)	(7,808,629)	319,543	(169,281,866)	(6,812,804)	-	(176,094,670)
Equipment	(275,787,226)	(18,649,088)	3,692,069	(290,744,245)	(18,920,746)	4,805,755	(304,859,236)
	(448,805,236)	(26,856,073)	4,011,612	(471,649,697)	(26,182,682)	4,805,755	(493,026,624)
Capital assets net of accumulated depreciation	150,943,266	869,924	(228,470)	151,584,720	(8,156,318)	(175,121)	143,253,281
Construction in progress	6,774,897	24,935,626	(22,321,668)	9,388,855	10,852,113	(14,949,045)	5,291,923
	$ 157,718,163	$ 25,805,550	$ (22,550,138)	$ 160,973,575	$ 2,695,795	$ (15,124,166)	$ 148,545,204

Depreciation expense totaled $26,182,683 and $26,856,073 for the years ended June 30, 2014 and 2013, respectively. Construction in progress at June 30, 2014 consists of various projects for additions and renovations to the Primary Health System's facilities. The estimated cost to complete construction projects is approximately $10,320,000.

During 2012, the Primary Health System entered into an agreement to sell certain professional office buildings (POBs) and concurrently entered into agreements to lease space from the purchaser. The sales price of the POBs was approximately $13,333,000, and a gain of approximately $6,695,000 was realized. Since the Primary Health System is leasing back certain space, a portion of the gain has been deferred and is being recognized over the terms of the leases. Amortization of the deferred gain is included in non-operating revenue (expenses) for the years ended June 30, 2014 and 2013.

The leases entered into (or committed to) under this sale/leaseback agreement include certain leases which meet the criteria for capitalization and are included in Note M.

NOTE F--INVESTMENTS AND ASSETS LIMITED AS TO USE

The Primary Health System invests in United States government and agency bonds, municipal bonds, corporate debt, certificates of deposit and short-term money market investments that are in accordance with the Primary Health System's investment policy. Temporary investments at June 30, 2014 consist primarily of cash equivalents, government bonds and commercial paper.

The carrying and estimated fair values for long-term investments, and assets limited as to use, by type, at June 30 are as follows:

	Primary Health System	
	2014	*2013*
U.S. Government and agency bonds, including municipal bonds, mutual funds, and other	$ 108,694,164	$ 111,569,814
Corporate bonds and commercial paper	7,004,219	4,348,798
Short-term investments and cash equivalents	16,556,196	16,131,637
Total investments and assets limited as to use	$ 132,254,579	$ 132,050,249

Assets limited as to use are classified as follows:

	Primary Health System	
	2014	*2013*
Capital investment funds	$ 101,463,961	$ 99,572,404
Under bond indentures - held by trustees	20,879,910	20,901,235
Self-insurance trust	6,098,629	6,318,010
Restricted by donors and other	3,485,940	3,467,654
	131,928,440	130,259,303
Less current portion	(7)	(28,275)
Total assets whose use is limited	$ 131,928,433	$ 130,231,028

Assets limited as to use for capital improvements are to be used for the replacement of property and equipment or for any other purposes so designated.

Funds held by trustees under bond indenture at June 30 are as follows:

	Primary Health System	
	2014	*2013*
Debt service reserve funds	$ 20,725,843	$ 20,718,915
Principal and interest funds	7	28,275
Other funds	154,060	154,045
Total funds held by trustees under bond indenture	$ 20,879,910	$ 20,901,235

These funds held by trustees consist primarily of United States government agency obligations, state and local government obligations, corporate debt, and other short-term investments and cash equivalents. The debt service reserve fund is to be used only to make up any deficiencies in other funds related to the Hospital Revenue and Refunding Bonds Series 1997A, Series 1998A, Series 2000 and Series 2004. The principal and interest funds are to be used only to pay

principal and interest, respectively, on the Series 1997A, Series 1998A, Series 2000 and Series 2004 bonds.

The Primary Health System's investment policy specifies the types of investments which can be included in board-designated assets limited as to use, as well as collateral or other security requirements. The investment policy also specifies the maximum maturity of the portfolio of board-designated assets. Assets limited as to use and held by trustees are invested as permitted by the bond indenture.

Custodial Credit Risk: The Primary Health System's investment securities are exposed to custodial credit risk if the securities are uninsured, are not registered in the name of the Primary Health System, and are held by either the counterparty or the counterparty's trust department or agent but not in the Primary Health System's name. The risk is that, in the event of the failure of the counterparty to a transaction, the Primary Health System will not be able to recover the value of the investment or collateral securities that are in the possession of an outside party.

As of June 30, 2014 and 2013, the Primary Health System's investments, including assets limited as to use, were comprised of various short-term investments, U.S. government and government agency bonds, municipal obligations, corporate bonds, commercial paper, and other U.S. Treasury obligations. Substantially all of the Primary Health System's investments, including assets limited as to use, are uninsured or unregistered. Securities are held by the counterparty, or by its trust department or agent, in the Primary Health System's name.

Concentration of Credit Risk: This is the risk associated with the amount of investments the Primary Health System has with any one issuer that exceeds 5% or more of its total investments. Investments issued or explicitly guaranteed by the U.S. Government and investments in mutual funds, external investment pools, and other pooled investments are excluded from this requirement. The Primary Health System's investment policy does not restrict the amount that may be held for any single issuer. At June 30, 2014, none of the Primary Health System's investments with any one issuer exceed 5% of its total investments except certain U.S. Government agencies.

Credit Risk: This is the risk that an issuer or other counterparty to an investment will not fulfill its obligations. GASB No. 40 requires that disclosure be made as to the credit rating of all debt security investments except for obligations of the U.S. Government or obligations explicitly guaranteed by the U.S. Government. The Primary Health System's investment policy provides guidelines for its fund managers and lists specific allowable investments.

The credit risk profile of the Primary Health System's investments, including assets limited as to use (excluding U.S. Government securities), as of June 30, 2014, is as follows:

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
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Notes to Combined Financial Statements - Continued

Years Ended June 30, 2014 and 2013

Investment Type	*Balance as of June 30, 2014*	*Rating*				
		AAA	*AA*	*A*	*BBB*	*N/A*
U.S Government agency bonds	$ 46,375,721	$ 44,799,453	$ 1,576,268	$ -	$ -	$ -
Municipal bonds	7,226,430	2,259,170	3,958,340	1,008,920	-	-
Bond mutual funds and other	5,575,435	5,575,435	-	-	-	-
Corporate bonds and commercial paper	1,428,784	-	-	1,428,784	-	-
Cash equivalents	16,556,196	-	-	-	-	16,556,196
Total investments	$ 77,162,566	$ 52,634,058	$ 5,534,608	$ 2,437,704	$ -	$ 16,556,196

Investment Rate Risk: This is the risk that changes in interest rates will adversely affect the fair value of an investment. The Primary Health System's investment policy authorizes a strategic asset allocation that is designed to provide an optimal return over the Primary Health System's investment horizon and within specified risk tolerance and cash requirements.

The distribution of the Primary Health System's investments, including assets limited as to use, and excluding the self-insurance trust, by maturity as of June 30, 2014, is as follows:

Investment Type	*Balance as of June 30, 2014*	*Remaining Maturity*				
		12 months or less	*13-24 Months*	*25-60 Months*	*Over 60 Months*	*N/A*
U.S. Government bonds and agency funds	$ 101,467,734	$ 15,624,278	$ 34,072,420	$ 14,086,664	$ 37,684,372	$ -
Municipal bonds	7,226,430	3,032,240	3,192,400	1,001,790	-	-
Corporate bonds and commercial paper	1,428,784	1,428,784	-	-	-	-
Cash equivalents	16,033,002	16,033,002	-	-	-	-
Total investments	$ 126,155,950	$ 36,118,304	$ 37,264,820	$ 15,088,454	$ 37,684,372	$ -

Additionally, the distribution of the Primary Health System's investments held under the self-insurance trust as of June 30, 2014, is as follows:

Investment Type	*Balance as of June 30, 2014*	*Remaining Maturity*				
		24 months or less	*25-60 Months*	*61-120 Months*	*Over 120 Months*	*N/A*
Bond Mutual Funds	$ 5,575,435	$ -	$ -	$ -	$ -	$ 5,575,435
Cash equivalents	523,194	523,194	-	-	-	-
Total investments	$ 6,098,629	$ 523,194	$ -	$ -	$ -	$ 5,575,435

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
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Notes to Combined Financial Statements - Continued

Years Ended June 30, 2014 and 2013

NOTE G--LONG-TERM DEBT

Long-term debt at June 30 consists of the following:

	Primary Health System	
	2014	*2013*
Revenue and Refunding Bonds, Series 2004, net of bond discount of $443,199 in 2014 and $532,793 in 2013 and including bond issue premium of $1,302,656 in 2014 and $1,443,483 in 2013	$ 66,859,457	$ 71,955,690
Hospital Revenue Refunding Bonds, Series 2000, including bond issue premium of $258,296 in 2014 and $281,255 in 2013	32,558,296	34,581,255
Hospital Revenue Bonds, Series 1998A, net of bond discount of $265,846 in 2014 and $280,615 in 2013	18,159,154	18,329,385
Hospital Revenue Bonds, Taxable Series 1997A	41,000,000	41,000,000
Total bonds payable	158,576,907	165,866,330
Other Loans and Notes Payable	4,978,158	5,630,515
Capital leases - Note M	6,575,290	6,741,204
	170,130,355	178,238,049
Less: current portion	(10,809,288)	(8,058,625)
	$ 159,321,067	$ 170,179,424

During fiscal year 2011, the Primary Health System entered into a term loan (the Loan) with a financial institution in the maximum amount of $7,000,000 to finance the acquisition of the Lifestyle Center property. The rate of interest on the loan is a fixed rate equal to 5.45%. Monthly payments of principal and interest are payable on the first day of each month for a 10 year term beginning December 1, 2010, with a final payment equal to the unpaid principal plus accrued and unpaid interest due at maturity. The loan contains certain covenants and restrictions. Management believes the Primary Health System was in compliance with all such covenants at June 30, 2014.

During fiscal year 2010, the Primary Health System remarketed the Series 2004 Hospital Revenue Refunding Bonds (Series 2004) and the Series 2000 Hospital Revenue Refunding Bonds (Series 2000), as described below, and converted such bonds from a variable auction rate to a fixed rate.

On January 1, 2004, the Primary Health System issued $85,000,000 insured Series 2004 bonds for the purpose of refunding $80,925,000 of the total outstanding Series 1993 bonds (described

below). The Primary Health System also utilized the proceeds to pay certain issuance costs and contributed a portion of the bond proceeds in the amount of $1,633,658 to establish a debt service fund.

The Series 2004 bonds were issued on parity, with respect to collateral, with other outstanding bonds, described below. The Series 2004 bonds are also secured by a mortgage on a portion of the Primary Health System's main campus. The Series 2004 bonds mature annually on October 1 beginning in 2010 through 2023 in varying amounts. The Series 2004 bonds maturing after October 1, 2019 (excluding those maturing on October 1, 2023) may be redeemed by the Primary Health System after October 1, 2019 at a redemption price equal to the principal amount plus accrued interest. The bonds maturing on October 1, 2023 may be redeemed prior to maturity pursuant to the extraordinary optional redemption and redemption upon damage or condemnation provisions as described in the Remarketing Memorandum by the Primary Health System after October 1, 2014 at a redemption price equal to 100% of the principal amount plus accrued interest. Interest rates for the outstanding Series 2004 bonds range from 3.0% to 5.0%.

In August 2000, the Primary Health System issued $47,300,000 insured Series 2000 bonds for the purpose of refunding $40,000,000 of then outstanding Series 1987 bonds and funding a debt service reserve fund in an original amount of $4,407,377 and to pay issuance costs. The Series 2000 bonds were issued on parity with other outstanding bond issues. The Series 2000 bonds consist of term bonds maturing on October 1, 2023 and serial bonds maturing on October 1 annually beginning in 2010 through 2025. The bonds maturing on October 1, 2023 are subject to mandatory sinking fund redemption prior to maturity and without premium at the principal amount thereof on October 1. The Series 2000 bonds maturing after October 1, 2014 may be redeemed by the Primary Health System after October 1, 2014 at a redemption price equal to the principal amount plus accrued interest.

Interest rates for the Series 2000 outstanding bonds are as follows:

Series Bonds	- 3.75% to 5.0%
Term Bonds	- 5.0%

The Primary Health System's 1997A and 1998A Hospital Revenue Bonds (Series 1997A and Series 1998A, respectively) were issued to fund capital improvements for Erlanger Medical Center and establish a debt service reserve fund (1998A only) in an original amount of $2,174,125.

The Series 1997A bonds are taxable and are secured on a parity under a Master Trust Indenture with other outstanding bond issues. The 1997A bonds mature beginning in fiscal year 2015 through fiscal year 2028. The 1997A bonds are subject to optional redemption at 100% plus

accrued interest and interest is payable at a variable auction rate for a 35-day period, which was 0.42% at June 30, 2014 and 0.49% at June 30, 2013.

The Series 1998A insured bonds are tax-exempt and consisted of $6,080,000 serial bonds maturing annually on October 1 of each year through 2013 in varying amounts; and term bonds maturing on October 1, 2018 and 2028 ($5,825,000 and $17,095,000, respectively). Such bonds are secured on parity with other outstanding bonds. The bonds maturing after October 1, 2008 may be redeemed by the Primary Health System after April 1, 2008 at amounts ranging from 100% to 101% of par value plus accrued interest.

Interest rates for the outstanding Series 1998A bonds are as follows:

$ 6,080,000 Serial Bonds	- 4.75% to 5.00%
$ 5,825,000 Term Bonds	- 5.0%
$17,095,000 Term Bonds	- 5.0%

During fiscal year 2002, the Primary Health System defeased $5,320,000 of the 1998A bond issuance because IRS regulations do not permit tax-exempt debenture proceeds to be used to fund for-profit endeavors. These funds were used in the construction of an Ambulatory Surgery Center. The Primary Health System contributed to an escrow account funds generated from its operations sufficient to fund all principal and interest payments for approximately $5,320,000 of debentures until maturity. The Primary Health System was released from being the primary obligor and cannot be held liable for the defeased obligation, of which approximately $4,140,000 remains outstanding at June 30, 2014.

The trust indentures and related documents underlying the bonds contain certain covenants and restrictions. As of June 30, 2014, management believes the Primary Health System is in compliance with all such covenants.

The Primary Health System's scheduled principal and interest payments (estimated for variable rate debt based on rates at June 30, 2014) on bonds payable and other long-term debt (excluding capital leases) are as follows for the years ending June 30:

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Notes to Combined Financial Statements - Continued

Years Ended June 30, 2014 and 2013

	Principal	*Interest*	*Total*
2015	$ 10,613,005	$ 5,868,787	$ 16,481,792
2016	11,637,069	5,391,616	17,028,685
2017	11,723,446	4,945,072	16,668,518
2018	12,674,484	4,515,962	17,190,446
2019	13,242,765	4,001,214	17,243,979
2020-2024	71,002,389	12,068,476	83,070,865
2025-2029	31,810,000	1,748,790	33,558,790
TOTAL	$ 162,703,158	$ 38,539,917	$ 201,243,075

Long-term debt activity for the Primary Health System for the years ended June 30, 2014 and 2013 consisted of the following:

	Balance at June 30, 2012	*Additions/ Amortizations*	*Reductions/ Accretions*	*Balance at June 30, 2013*	*Additions/ Amortizations*	*Reductions/ Accretions*	*Balance at June 30, 2014*
Bonds Payable							
Series 2004	$ 76,754,321	$ 152,197	$ 4,950,828	$ 71,955,690	$ 89,594	$ 5,185,827	$ 66,859,457
Series 2000	36,404,215	-	1,822,960	34,581,255	-	2,022,959	32,558,296
Series 1998A	18,859,616	14,769	545,000	18,329,385	14,769	185,000	18,159,154
Series 1997A	41,000,000	-	-	41,000,000	-	-	41,000,000
Total bonds payable	173,018,152	166,966	7,318,788	165,866,330	104,363	7,393,786	158,576,907
Term Loan	6,282,894	-	652,379	5,630,515	-	652,357	4,978,158
Capital leases	6,834,667	-	93,463	6,741,204	-	165,914	6,575,290
Total long-term debt	$ 186,135,713	$ 166,966	$ 8,064,630	$ 178,238,049	$ 104,363	$ 8,212,057	$ 170,130,355

NOTE H--PENSION PLAN

The Primary Health System sponsors a single-employer, non-contributory defined benefit pension plan covering substantially all employees meeting certain age and service requirements. In addition to normal retirement benefits, the plan also provides for early retirement, delayed retirement, disability and death benefits. The Primary Health System funds the plan as contributions are approved by the Board of Trustees. The Primary Health System has the right to amend, in whole or in part, any or all of the provisions of the plan. Effective July 1, 2009, the plan was amended to be closed to new employees or rehires, and to further clarify the maximum years of service to be 30. During June 2014, the plan was amended to freeze the accrual of additional benefits going forward. The actuarial computations below do not include the impact of this amendment.

The plan issues a publicly available financial report that includes a financial statement and required supplementary information for the plan. That report may be obtained by writing to

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
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Notes to Combined Financial Statements - Continued

Years Ended June 30, 2014 and 2013

Erlanger Health System, Attention: Human Resources Department, 975 East Third Street, Chattanooga, Tennessee 37403 or by calling 423-778-7000.

The annual pension cost and net pension obligation for the years ended June 30, 2014 and 2013 are as follows:

	Primary Health System	
	2014	*2013*
Annual required contribution	$ 12,832,292	$ 11,165,100
Interest on net pension obligation	782,963	791,073
Adjustment to annual required contribution	(1,024,034)	(899,189)
Annual pension cost	12,591,221	11,056,984
Contributions made	-	(11,165,100)
Change in net pension obligation	12,591,221	(108,116)
Net pension obligation at beginning of year	10,439,507	10,547,623
Net pension obligation at end of year	$ 23,030,728	$ 10,439,507

The annual expected contribution for the years ended June 30, 2014 and 2013, was determined as part of the January 1, 2014 and 2013 actuarial valuations, respectively, using the projected unit credit cost method. The following actuarial assumptions were utilized:

	2014	*2013*
Investment rate of return	7.5%	7.5%
Projected salary increases	4.0%	4.0%
Inflation	2.5%	2.5%
Increase in Social Security taxable wage base	3.5%	3.5%

Annual pension costs, contribution information and the net pension obligation for the last three fiscal years follows:

	Three-Year Trend Information		
Fiscal Year Ending	*Annual Pension Cost (APC)*	*Percentage of APC Contributed*	*Net Pension Obligation*
June 30, 2012	$ 10,264,968	101%	$ 10,547,623
June 30, 2013	11,056,984	101%	10,439,507
June 30, 2014	12,591,221	0%	23,030,728

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The schedule of funding progress shown below presents multi-year trend information about whether the actuarial value of plan assets is increasing or decreasing over time relative to the actuarial accrued liability for benefits. The actuarial asset values are determined using prior year valuations with the addition of current year contributions and expected investment return on market value of assets based on an assumed rate of 7.5%, and deducting benefit payments and administrative expenses for the year. The actuarial value of assets was determined using techniques that smooth the effects of short-term volatility in the market value of investments using an average of cost and market value. The plan will reset the amortization base each year equal to the unfunded actuarial accrued liability to be amortized over a closed 20 year period and using a level dollar amount as the amortization factor.

Schedule of Funding Progress

Actuarial Valuation Date	*Actuarial Value of Assets*	*Actuarial Accrued Liability (AAL)*	*Total Unfunded AAL (UAAL)*	*Funded Ratio %*	*Annual Covered Payroll*	*UAAL as a Percentage of Covered Payroll*
1/1/11	$125,335,932	$ 150,926,741	$25,590,809	83.0%	$ 147,947,134	17.3%
1/1/12	124,520,999	160,704,688	36,183,689	77.5%	138,807,819	26.1%
1/1/13	121,700,323	170,980,311	49,279,988	71.2%	121,093,695	40.7%

NOTE I--OTHER RETIREMENT PLANS

The Primary Health System maintains defined contribution plans under Section 403(b) and 401(a) of the IRC which provides for voluntary contributions by employees. The Plans are for the benefit of all employees 25 years of age or older with at least 12 months of employment.

The Primary Health System matches 50% of each participant's contribution up to 2% of the participant's earnings. Additionally, for eligible employees hired on after July 1, 2009 the Primary Health System will make profit sharing contributions equal to 3% of their earnings, regardless if the employee is making contributions. Employer contributions to the plan were approximately $1,770,000 and $1,830,000 for the years ended June 30, 2014 and 2013, respectively.

NOTE J--POST-EMPLOYMENT BENEFITS OTHER THAN PENSIONS

The Primary Health System sponsors three post-employment benefit plans other than pensions (OPEB) for full-time employees who have reached retirement age, as defined. The respective plans provide medical, dental, prescription drug and life insurance benefits, along with a limited lump-sum cash payment for a percent of the hours in the participant's short-term disability at retirement. The postretirement health, dental and prescription drug plan is contributory and

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contains other cost-sharing features, such as deductibles and coinsurance. The life insurance plan and the short-term disability are noncontributory.

During 2014, the postretirement health, dental and prescription drug plan was amended to increase the amount of required participant contributions. Additionally, eligibility for the short-term disability was limited to employees that had attained age 55 and completed 10 years of service as of January 1, 2014 or attained age 65 with at least 5 years of service as of this date. The lump-sum payout for the short-term disability was also reduced from 50% to 20% of the amount accumulated.

Beginning in 2018, under the Patient Protection and Affordable Care Act (the Act), a 40% excise tax will be imposed on the excess benefit provided to an employee or retiree in any month under any employer-sponsored health plan. In the case of a self-insured plan, the plan administrator must pay the tax. Because of the significant uncertainties regarding the excise tax on high cost plans, management of the Primary Health System is evaluating the impact of this Act but does not anticipate a material impact on the accrued liability at this time; however, actual results could differ from these estimates.

The following table shows the plans, funded status as of June 30:

	2014	*2013*
Actuarial accrued liability	$ 16,773,895	$ 30,500,450
Market value of assets	-	-
Unfunded actuarial accrued liability	$ 16,773,895	$ 30,500,450

The following is a summary of the components of the annual OPEB cost recognized by the Primary Health System for the years ended June 30:

	2014	*2013*
Annual required contribution	$ 2,032,983	$ 2,945,355
Interest on the net obligation	153,565	228,288
Adjustment for plan amendment	(3,127,421)	-
Amortization of net obligation	(152,570)	(226,809)
OPEB cost (benefit) recognized	$ (1,093,443)	$ 2,946,834

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
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Notes to Combined Financial Statements - Continued

Years Ended June 30, 2014 and 2013

A reconciliation of the net OPEB obligation for the fiscal years ended June 30 is as follows:

	2014	2013
Net OPEB obligation beginning of the year	$ 6,966,545	$ 5,707,193
OPEB cost (benefit) recognized	(1,093,443)	2,946,834
Actual contributions	(2,223,494)	(1,687,482)
Net OPEB obligation end of the year	$ 3,649,608	$ 6,966,545

Trend Information

Fiscal Year Ending	Annual OPEB Cost (Benefit)	Percentage of Annual OPEB Cost Contributed	Net OPEB Obligation at the End of Year
July 1, 2012	$ 2,666,393	39.6%	$ 5,707,193
July 1, 2013	2,946,834	57.3%	6,966,545
July 1, 2014	(1,093,443)	N/A	3,649,608

Schedule of Funding Progress

Actuarial Valuation Date	Actuarial Value of Assets	Actuarial Accrued Liability	Unfunded Actuarial Accrued Liability	Annual Covered Payroll	Unfunded Actuarial Accrued Liability as a Percent of Covered Payroll	Funded Ratio
July 1, 2012	$ -	$ 28,788,147	$ 28,788,147	$138,807,819	20.7%	0%
July 1, 2013	-	30,500,450	30,500,450	155,727,806	19.6%	0%
July 1, 2014	-	16,773,895	16,773,895	167,104,474	10.0%	0%

The actuarial calculations reflect a long-term perspective. Accordingly, the actuarial valuation involves estimates of the value of reported amounts and assumptions about the probability of events far into the future, and actuarially determined amounts are subject to continual revision as actual results are compared to past expectations and new estimates are made about the future.

The schedule of funding progress presents multi-year trend information about whether the actuarial value of plan assets is increasing or decreasing over time relative to the actuarial accrued liability. The calculations are based on the benefits currently provided under the terms of the plan as of the date of each valuation and on the sharing of cost between employer and plan members at that point.

The actuarial cost method utilized is the unit credit actuarial cost method. The 2014 and 2013 postretirement benefit cost assumed an average weighted annual rate increase in per capita cost of covered health benefits of 7.4%, decreasing gradually to an ultimate rate of 4.8%.

The amortization method used is the level percent of payroll method over a thirty-year amortization. Other assumptions include a 4% discount rate and assumed salary increases of 4.0% annually until age 65.

The Primary Health System also has a job injury program to provide benefits to workers injured in employment-related accidents. This program provides medical and indemnity benefits to employees injured in the course of employment for a period up to 24 months from the date of injury. The Primary Health System has recorded a projected liability that is included in other long-term liabilities in the combined statements of net position. The projected liability was discounted using a 4% rate of return at June 30, 2014 and 2013.

NOTE K--MEDICAL MALPRACTICE AND GENERAL LIABILITY CLAIMS

As of January 1, 1976, the Primary Health System adopted a self-insurance plan to provide for malpractice and general liability claims and expenses arising from services rendered subsequent to that date. In 1980, the Primary Health System's Self-Insurance Trust Agreement (the Agreement) was amended to include all coverages that a general public liability insurance policy would cover. In 1988, the Agreement was amended and restated to comply with amendments to the Tennessee Governmental Tort Liability Act and to formally include any claims and expenses related to acts of employees of the Primary Health System. The Primary Health System is funding actuarial estimated liabilities through a revocable trust fund with a bank. The trust assets are included as a part of assets limited as to use in the accompanying combined statements of net position. Such amounts in the trust can be withdrawn by the Primary Health System only to the extent there is an actuarially determined excess. The annual deposit to the self-insurance trust fund is determined by management based on known and threatened claims, consultation with legal counsel, and a report of an independent actuary. Losses against the Primary Health System are generally limited by the Tennessee Governmental Tort Liability Act to $300,000 for injury or death to any one person in any one occurrence or $700,000 in the aggregate. However, claims against healthcare practitioners are not subject to the foregoing limits applicable to the Primary Health System. Any such individuals employed by the Primary Health System, excluding employed physicians for which the Primary Health System has purchased insurance coverage, are covered by the Trust to the limits set forth therein.

In the opinion of management, the revocable trust fund assets are adequate at June 30, 2014, to cover potential liability and malpractice claims and expenses that may have been incurred to that date.

The Primary Health System provides for claims and expenses in the period in which the incidence related to such claims occur based on historical experience and consultation with legal counsel. It is the opinion of management that the reserve for estimated losses and loss adjustment expense (LAE) at June 30, 2014 is adequate to cover potential liability and

malpractice claims which may have been incurred but not reported (IBNR) to the Primary Health System. Such reserve for IBNR claims reflects a discount rate of 5.5% based on the Primary Health System's expected investment return during the payout period.

NOTE L--COMMITMENTS AND CONTINGENCIES

Litigation: The Primary Health System is subject to claims and suits which arise in the ordinary course of business. In the opinion of management, the ultimate resolution of such pending legal proceedings has been adequately provided for in its combined financial statements, and will not have a material effect on the Primary Health System's results of operations or financial position.

The prior Chief Executive Officer (CEO) resigned from Erlanger on December 31, 2011, after an interim CEO (the Executive Vice President) was established December 1, 2011. The interim CEO was replaced by the current CEO, hired on April 1, 2013. The Executive Vice President's employment at Erlanger ended when her leave expired in June, 2013. She has filed a wrongful termination lawsuit against Erlanger for $25 million, which Erlanger, in conjunction with its Directors and Officers insurance carrier, is currently defending. The ultimate outcome of this lawsuit is uncertain.

Regulatory Compliance: The healthcare industry is subject to numerous law and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, Medicare fraud and abuse, and most recently under the Provision of Health Insurance Portability and Accountability Act of 1996, matters related to patient records, privacy and security. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers, such as the Medicare Recovery Audit Contractor Program. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or un-asserted at this time.

In the normal course of business, the Primary Health System continuously monitors and investigates potential issues through its compliance program. Currently several investigations related to potential non-compliance are underway and the Primary Health System recognizes a liability when it is determined to exist and the amount can be reasonably estimated. Management currently believes that the Primary Health System is in compliance with applicable laws and regulations or has reported any amounts payable related known violations, including amounts identified through the Medicare Recovery Audit Contractor program, or similar initiatives, and any settlements will not have a significant impact on the combined financial

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statements. However, due to the uncertainties involved and the status of ongoing investigations, management's estimate could change in the near future and the amount of the change could be significant.

Health Care Reform: In March 2010, Congress adopted comprehensive healthcare insurance legislation, Patient Care Protection and Affordable Care Act and Health Care and Education Reconciliation Act. The legislation, among other matters, is designated to expand access to coverage to substantively all citizens by 2019 through a combination of public program expansion and private industry health insurance. Changes to existing TennCare and Medicaid coverage and payments are also expected to occur as a result of this legislation. Implementing regulations are generally required for these legislative acts, which are to be adopted over a period of years and, accordingly, the specific impact of any future regulations is not determinable.

NOTE M--LEASES

Capital: As discussed in Note E, during 2012, the Primary Health System entered into a sale/leaseback arrangement, under which certain leases of office space meet the criteria as capital leases. Interest on these leases has been estimated at 7% per annum.

During 2011, the Primary Health System acquired a parcel of land from the Industrial Development Board of the City of Chattanooga, Tennessee for a nominal amount. The Primary Health System also entered into a project development agreement with a developer to facilitate final design, financing and construction of a medical office building for the benefit of Volkswagen Group of America Chattanooga Operations, LLC (Volkswagen) on this land. The Primary Health System has entered into a forty-year ground lease, with the option of two ten-year renewal terms, of the parcel to the developer. Additionally, in 2012, the Primary Health System has entered into a twenty year lease with the developer for certain space in the medical office building for a wellness center and other operations under a capital lease agreement.

The following is an analysis of the property under capital leases by major classes at June 30:

	Primary Health System	
	2014	*2013*
Buildings	$ 6,601,812	$ 6,601,812
Equipment	494,905	494,905
	7,096,717	7,096,717
Less: accumulated amortization	(1,177,444)	(593,019)
	$ 5,919,273	$ 6,503,698

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The following is a schedule of future minimum lease payments under capital leases:

Year Ending June 30,	
2015	$ 773,890
2016	739,815
2017	729,999
2018	744,453
2019	759,311
2020-2024	3,779,120
2025-2029	4,055,430
2030-2034	1,848,126
Total minimum lease payments	13,430,144
Less: amount representing interest	(6,854,854)
Present value of minimum lease payments (including current portion of $196,283)	$ 6,575,290

Operating: The Primary Health System rents office space and office equipment under non-cancelable operating leases through 2033, containing various lease terms. The leases have other various provisions, including sharing of certain executory costs. Rent expense under operating leases was approximately $7,840,000 and $7,450,000 in 2014 and 2013, respectively. Future minimum lease commitments at June 30, 2014 for all non-cancelable leases with terms in excess of one year are as follows:

Year Ending June 30,	
2015	$ 6,200,885
2016	3,539,847
2017	3,434,456
2018	2,666,047
2019	2,436,867
Thereafter	19,823,183
	$ 38,101,285

Rental Revenues: The Primary Health System leases office space to physicians and others under various lease agreements with terms in excess of one year. Rental revenue recognized for the years ended June 30, 2014 and 2013 totaled approximately $3,688,000 and $4,261,000, respectively. The following is a schedule of future minimum lease payments to be received for the years ending June 30:

Year Ending June 30,	
2015	$ 1,915,427
2016	1,140,038
2017	748,170
2018	533,963
2019	413,203
Thereafter	1,302,421
	$ 6,053,222

NOTE N--DERIVATIVE FINANCIAL INSTRUMENTS

Simultaneous with the issuance of the $85,000,000 Series 2004 bonds discussed in Note G, the Primary Health System entered into interest rate swap agreements. In an effort to take advantage of the differences between taxable and tax-exempt debt, and manage exposure to interest rate risks associated with various debt instruments, the Primary Health System is currently a party to two distinct interest rate swap agreements with a third party.

With respect to the 1997A Series bonds, the Primary Health System executed a swap agreement whereby the Primary Health System receives a variable rate equal to the one-month LIBOR-BBA rate and pays a fixed rate equal to 5.087% on a notional amount of $41,000,000. Unless terminated at an earlier date (at the Primary Health System's option), this agreement terminates on October 1, 2027.

With respect to the 1998A Series bonds, the Primary Health System executed a swap agreement whereby the Primary Health System receives a fixed rate of 3.932% and pays a variable rate equal to the Securities Industry and Financial Markets Association (SIFMA) Municipal Swap Index on a notional amount of $16,305,000. Unless terminated at an earlier date (at the Primary Health System's option), this agreement terminates on October 1, 2027.

Although these swap instruments are intended to manage exposure to interest rate risks associated with the various debt instruments referred to above, none of these swap agreements have been determined to be effective hedges. Accordingly, the interest rate swaps are reflected in the accompanying combined statements of net position at their aggregate fair value (a net liability of $3,982,646 and $4,856,429 at June 30, 2014 and 2013, respectively) and the changes in the value of the swaps are reflected as a component of non-operating revenues in the combined statements of revenue, expenses and changes in net position.

Management has considered the effects of any credit value adjustment and while management believes the estimated fair value of the interest rate swap agreements is reasonable, the estimate is subject to change in the near term.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
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Notes to Combined Financial Statements - Continued

Years Ended June 30, 2014 and 2013

NOTE O--MANAGEMENT AGREEMENT

On April 13, 2011, the Primary Health System's Board of Trustees approved a resolution authorizing a management agreement (the Agreement) between the Primary Health System, Hutcheson Medical Center, Inc. and affiliates (collectively, Hutcheson) and the Hospital Authority of Walker, Dade and Catoosa Counties in Georgia (the Hospital Authority).

Under the terms of the Agreement, the Primary Health System proposed general operating policies and directives for Hutcheson; was responsible for the day-to-day management of Hutcheson and provided oversight of ancillary aspects of Hutcheson, such as physician practices, education, research, and clinical services. The Agreement's initial term was to be through March 31, 2021 with the Primary Health System to have the option to extend the agreement for two additional five year terms. The Primary Health System was authorized to terminate the Agreement, without cause, upon written notice at any point subsequent to May 25, 2013. Upon such termination, Hutcheson was to be obligated to make a Termination Payment to the Primary Health System consisting of all expenses then owed by Hutcheson and any outstanding advances under a Line of Credit Agreement, discussed below. Hutcheson could also terminate the agreement without cause at any point subsequent to May 25, 2013 by paying the Termination Payment, as well as the lesser of a) $1,000,000 per year for each year the Agreement has been in place, or b) $1,000,000 less any management fees paid in each Agreement year.

In addition to the Agreement, the Primary Health System agreed to extend a Line of Credit (the Line) to the Hospital Authority. The maximum amount available under the initial Line was $20,000,000. During the year ending June 30, 2013, the Agreement was amended to increase the maximum amount to $20,550,000. At June 30, 2014, the draws on the Line totaled $20,550,000.

The Line called for interest only payments each month on the outstanding balance, based on the London InterBank Offered Rate plus 4% or a rate of 5%, whichever is greater. However, any unpaid interest through March 31, 2013 was deferred and to be paid over a twelve-month period commencing on that date. All outstanding draws were due at the maturity date, which is consistent with the Agreement termination dates, discussed above.

The Line is secured by a Security Agreement on the primary Hutcheson medical campus. Further, the Counties of Walker and Catoosa, Georgia (collectively, the Counties) have provided additional security in the form of guarantees under an Intergovernmental Agreement. Under the Intergovernmental Agreement, the Counties have each agreed to a maximum liability of $10,000,000 to secure the line. The form of such guarantee was to be at the option of the Counties and were to become enforceable upon a notice of default delivered by the Primary Health System. The form of the guarantee selected by the Counties can include a) a payment of 50% by each County of the amounts owing under the Line, b) payments as they become due up to the respective $10,000,000 limits or c) after non-Judicial foreclosure under the Security

Agreement, each County could elect to pay 50% of any deficiency between the amount outstanding under the Line and the then fair market value. Both Counties previously agreed to levy annual property taxes, if needed to honor these guarantees.

In June 2013, the Agreement was modified to allow Hutcheson to issue requests for proposals for the lease or sale of Hutcheson properties without creating a breach of the Agreement. As part of the Agreement, Hutcheson committed to obtain alternative financing and repay the line of credit upon the earlier of the replacement financing being obtained by Hutcheson, or June 1, 2014.

In August of 2013, however, Hutcheson terminated the Agreement. In response thereto, the Primary Health System declared Hutcheson to be in default under the Agreement and made formal demand of Hutcheson as to all amounts then due and payable. In February 2014, the Primary Health System filed suit against Hutcheson in order to collect the moneys, including principal, interest and penalties, then due. In response to such filing, Hutcheson has asserted multiple counter claims against the Primary Health System alleging mismanagement and other failures under the Agreement. Additionally, another senior creditor has filed a separate lawsuit against the Primary Health System alleging priority over the Primary Health System's security interest and, presumably, the County guarantees relating to Hutcheson. The litigation is currently pending in the United States District Court in the Northern District of Georgia, Rome Division

NOTE P--OTHER REVENUE

The American Recovery and Reinvestment Act of 2009 and the Health Information Technology for Economic and Clinical Health (HITECH) Act established incentive payments under the Medicare and Medicaid programs for certain healthcare providers that use certified Electronic Health Record (EHR) technology. To qualify for incentive payments, healthcare providers must meet designated EHR meaningful use criteria as defined by the Centers for Medicare & Medicaid Services (CMS). Incentive payments are awarded to healthcare providers who have attested to CMS that applicable meaningful use criteria have been met. Compliance with meaningful use criteria is subject to audit by the federal government or its designee and incentive payments are subject to adjustment in a future period.

The Primary Health System recognizes revenue for EHR incentive payments when substantially all contingencies have been met. During 2014 and 2013, the Primary Health System recognized approximately $4,220,000 and $2,670,000, respectively, of other revenue related to EHR incentive payments.

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NOTE Q--CONDENSED FINANCIAL INFORMATION

The following is condensed, financial information related to the discretely presented component units as of and for the years ended June 30, 2014 and 2013:

	ContinuCare	*Cyberknife*
As of June 30, 2014		
Due from other governments	$ 192,950	$ 176,300
Other current assets	10,345,848	460,017
Total Current Assets	10,538,798	636,317
Net property, plant and equipment	4,885,489	4,120,144
Other assets	882,663	64,013
Total Assets	$ 16,306,950	$ 4,820,474
Due to other governments	$ 126,882	$ -
Other current liabilities	2,564,259	655,526
Total Current Liabilities	2,691,141	655,526
Long-term debt and capital lease obligations	51,653	3,092,057
Total Liabilities	2,742,794	3,747,583
Net position		
Unrestricted	8,759,244	556,940
Net investment in capital assets	4,804,912	515,951
Total Net Position	13,564,156	1,072,891
Total Liabilities and Net Position	$ 16,306,950	$ 4,820,474
Year Ended June 30, 2014		
Net patient and operating revenue	$ 26,429,529	$ 1,900,600
Operating expenses:		
Salaries, wages and benefits	13,407,246	231,342
Supplies and other expenses	12,497,767	702,098
Depreciation	549,539	560,208
Total Operating Expenses	26,454,552	1,493,648
Operating Income (Loss)	(25,023)	406,952
Nonoperating revenue (expenses)	389,611	(172,007)
Change in Net Position	364,588	234,945
Net Position at Beginning of Period	13,199,568	837,946
Net Position at End of Period	$ 13,564,156	$ 1,072,891

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Notes to Combined Financial Statements - Continued

Years Ended June 30, 2014 and 2013

	ContinuCare	*Cyberknife*
As of June 30, 2013		
Due from other governments	$ 248,239	$ 129,000
Other current assets	8,865,703	490,008
Total Current Assets	9,113,942	619,008
Net property, plant and equipment	5,174,936	4,468,880
Other assets	2,383,609	75,309
Total Assets	$ 16,672,487	$ 5,163,197
Due to other governments	$ 408,032	$ 120,000
Other current liabilities	3,035,595	788,584
Total Current Liabilities	3,443,627	908,584
Long-term debt and capital lease obligations	29,292	3,416,667
Total Liabilities	3,472,919	4,325,251
Net position		
Unrestricted	8,110,622	210,424
Net investment in capital assets	5,088,946	627,522
Total Net Position	13,199,568	837,946
Total Liabilities and Net Position	$ 16,672,487	$ 5,163,197
Year Ended June 30, 2013		
Net patient and operating revenue	$ 26,026,863	$ 1,560,900
Operating expenses:		
Salaries, wages and benefits	13,395,486	211,954
Supplies and other expenses	12,897,677	578,266
Depreciation	517,483	527,752
Total Operating Expenses	26,810,646	1,317,972
Operating Income (Loss)	(783,783)	242,928
Nonoperating revenue (expenses)	497,259	(194,623)
Change in Net Position	(286,524)	48,305
Net Position at Beginning of Period	13,486,092	789,641
Net Position at End of Period	$ 13,199,568	$ 837,946

ContinuCare owes the Primary Health System for various services, supplies, and rents provided, or expenses paid on its behalf. Actual expenses incurred related to these services were $1,925,245 and $2,119,466 in 2014 and 2013, respectively. In addition, ContinuCare provides staffing, contract nurse visits, and administrative services to the Primary Health System. Revenues from such services were $372,554 and $617,427 for the years ended 2014 and 2013, respectively. Amounts due at June 30, 2014 and 2013 are included in amounts due to/from other governments in the accompanying combined financial statements.

As of June 30, 2014 and 2013, Cyberknife owes the Primary Health System for various services, supplies and rents provided, or expenses paid on its behalf. The Primary Health System owes Cyberknife for radiation services provided by Cyberknife to the Primary Health System's patients. Revenues related to those services provided to the Primary Health System were $1,900,600 and $1,560,900 in 2014 and 2013, respectively. Amounts due at June 30, 2014 and 2013 are included in amounts due to/from other governments in the accompanying combined statements of net position.

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax:615/532-9940

September 19, 2014

Mr. Joseph M. Winick
Senior Vice President –Planning & Business Development
Erlanger Health System
975 East 3rd Street
Chattanooga, Tennessee 37403

RE: Certificate of Need Application CN1409-038
Erlanger Medical Center

Dear Mr. Winick,

This will acknowledge our September 12, receipt of your application for a Certificate of Need for the addition of a 3.0 T Magnetic Resonance Imaging (MRI) scanner at Erlanger Medical Center, 975 East 3rd Street, Chattanooga (Hamilton County), Tennessee.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 p.m., September 26, 2014. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

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1. **Section A, Applicant Profile, Item 2 (Applicant Profile)**

   Please note the association of the contact person with the owner.

2. **Section A, Applicant Profile, Item 5 (Management/Operating Entity)**

   Please provide a copy of the management/operating agreement. If the applicant will be managing itself, please provide a replacement noting N/A as the response.

3. **Section A, Applicant Profile, Item 6**

   The Agency will need a deed, a purchase agreement, lease agreement, option to lease or other legal document which demonstrates the applicant has a legitimate legal interest in the property on which to locate the project.

4. **Section A, Applicant Profile, Item 13**

   The applicant's contract with United Health Plan is noted. However, please clarify why the applicant does not have a contract with United Healthcare Community Plan for TennCare enrollee's over the age of 21.

   New TennCare Managed Care Contract with the Bureau of TennCare will take effect January 1, 2015 with full statewide implementation for AmeriGroup, BlueCare Tennessee and United healthcare. Please indicate the stages of contract discussions with each MCO for these new contracts.

5. **Section B. Item I (Project Description),**

   Please provide a brief description of the following: proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing. Please list each area and provide a brief response underneath.

6. **Section B Item Project Description II.C.**

   The applicant states on July 2, 2014 a 3rd shift (night shift) was implemented in the MRI department. Please clarify the hours of the night shift. In July and August 2014 how many MRI scans were conducted during the following shifts?) 7-3____: 3-11_____, and 11-7____.

   The applicant states in 2013 759 patients that required 3.0 Tesla Imaging were referred for services. Please indicate where these patients were referred.

7. **Section B Item Project Description II.E 1.b and 1.3**

   The hours of operation for the existing 3 MRIs and the proposed 3T MRI is noted. However, please clarify why the 3T MRI will not be open from 7 am-8 am and 8 pm-11 pm Mon-Sat, and not open on Sundays. During those times and from 11 pm to 7 am, where will patients who need 3T MRI services be referred?

   It is noted the applicant will purchase the 3T MRI. However, please itemize the $3,013,702 cost for fixed equipment in the Project Costs Chart. This amount is not found in the Equipment Quote found in Attachment A-59.

   The applicant indicates the clinical applications for proposed 3.0 Tesla MRI include: Neurological Imaging, Orthopedic Imaging, and Pediatric Imaging Please discuss the clinical advantages of images acquired by a 3.0 Tesla MRI vs. a 1.5 Tesla MRI in each of the above specialty areas.

8. **Section B Item IV (Floor Plan)**

   The floor plan is noted. However, please note the location of the proposed 3T MRI on the floor plan and resubmit.

9. **Section C, Need, Item 1 (Specific Criteria, Magnetic Resonance Imaging (1.)(a.))**

   The applicant states a 3.0 Tesla MRI is becoming the standard of care in imaging in Orthopedics, Neurology, and Pediatrics. Please provide documentation to verify that statement.

   The proposed 3T MRI projected volume includes reallocation from the other three MRI's due to over capacity. The reallocation ranges from 665 in Year 1 to 950 in Year 2. Please clarify if the allocation cases would be the most clinically appropriate for a 3T MRI.

   After the relocation from the 3 existing MRIs to the proposed 3T MRI, please complete the following table:

Projected Volume

	Year One	Year Two	Year Three
MRI#1			
MRI #2			
MRI #3			
Proposed 3T			
Total			

10. **Section** C, Need, Item 1 (Specific Criteria, Magnetic Resonance Imaging (2)

    The applicant notes the Georgia Department of Community Health does not maintain data for MRI units. Please provide the location of MRI units in the applicant's Northwest Georgia service area.

11. Section C, Need, Item 1 (Specific Criteria, Magnetic Resonance Imaging (3)

    Please indicate if there is a waiting list for 3T MRI appointments. In general what is the wait time for an MRI at Erlanger?

12. Section C, Need, Item 1 (Specific Criteria, Magnetic Resonance Imaging (4)

    The chart of MRI utilization in Southeast Tennessee is noted. However, please revise the chart to include the Tesla Strength of each MRI in the proposed service area and provide a replacement page for page 34.

13. Section C, Need, Item 1 (Specific Criteria, Magnetic Resonance Imaging (7.b) The letter from the architect is noted. However, please submit a revised letter that demonstrates the proposed MRI will meet applicable federal standards, manufacturer specifications and licensing agencies' requirements.

14. Section C, Need, Item 1 (Specific Criteria, Magnetic Resonance Imaging (7) (g.) and Orderly Development, Item 1

    The list of transfer agreements in Attachments A-21 through A-24 is noted. However, the list is out of date and is expired. Please provide a current list.

15. Section C, Need, Item 3.

The county level map of the applicant's service area is noted. However, please submit a revised map that provides legible county names. In addition, please label Georgia service area counties.

16. Section C Item I (Need) and Section C Item 5

The table of primary acute hospital general utilization trends in the service area is noted. However, since the applicant is applying for a 3T MRI, please provide utilization for each of the most recent three years of data available for MRIs in the proposed service area.

If applicable, please describe any approved but unimplemented CONs for MRI services in the proposed service area.

17. Section C Item I (Need) and Section C Item 6 (Applicant's Utilization)

The general utilization for Erlanger Medical Center is noted. However, please respond to the question specific to MRI services.

18. Section C, Need, Item 4

Your response to this item is noted. Please complete the following chart. All the information requested can be obtained from the Department of Health population projections, TennCare website, and US Census website.

Demographic /Geographic Area	Bledsoe	Bradley	Grundy	Hamilton	Marion	MCMinn	Meigs	Polk	Rhea	Sequatchie	Primary Service Area	State of TN
Total Population-Current Year -2014												
Total Population-Projected Year -2018												
Total Population-% change												
Median Age												
Median Household Income												
TennCare Enrollees												
TennCare Enrollees as % of Total Pop.												
Persons Below Poverty Level												
Persons Below Poverty Level as % of Total												

19. Section C, Economic Feasibility, Item 2

The applicant notes the proposed project will be funded from cash reserves. However, the funding letter in the attachments notes the proposed project will be funded from operations. Since the historical data chart indicates the applicant has operated at a loss for the past 3 years, please revise the letter to indicate the project will be funded through cash reserves and resubmit.

20. Section C, Economic Feasibility, Item 1 (Historical & Projected Data Charts)

There appears to be errors in the Year One "total operating expense category" of the Projected Data Chart. Please revise and resubmit.

The applicant has not designated management fees in the historical and projected data charts. Please verify the applicant does not pay management fees to affiliates.

The Projected Data Chart is noted. Please complete the following table and place the tables on separate pages labeled 51A and 52A, respectively to be located after the Historical and Projected Data Charts.

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year____	Year___
1.	$_____	$_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
Total Other Expenses	$_____	$_____

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	**Year____**	**Year___**	***Year____***
1.	$_____	$_____	$_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
Total Other Expenses	$_____	$_____	$_____

The historical chart indicates the applicant has operated at a loss of approximately $12 million in 2011, $26 million in 2012, and $24 million in 2013. Please provide a Projected Data Chart for Erlanger Medical Center for Year One and Year Two of the proposed project.

21. Section C. (Economic Feasibility) Question 5

The average gross charge, average deduction and average net charge are noted. However, please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project.

22. Section C. (Economic Feasibility) Question 6.A

Please respond to this question specific to the proposed MRI service.

23. Section C. (Economic Feasibility) Question 6.B

Please compare the proposed MRI Gross Charges per Procedure/Treatment by quartiles for using the following table:

Gross Charges per Procedure/Treatment
By Quartiles
YEAR = 2013

Equipment Type	1st Quartile	Median	3rd Quartile
MRI	$1,570.39	$2,175.15	$3,498.94
Source: Medical Equipment Registry – 8/11/2014			

24. **Section C. (Economic Feasibility) Question 7**

Please respond to this question specific to the proposed MRI service.

25. **Section C. (Economic Feasibility) Question 8**

Please demonstrate the availability of sufficient cash flow until financial viability is achieved

26. **Section C, Economic Feasibility, Item 9**

Please indicate the percentage of total project revenue anticipated from each of TennCare/Medicaid or other state and federal sources for the proposal's first year of operation.

Please indicate how medically indigent patients will be served by the project.

27. **Section C , Economic Feasibility, Item 11**

One of the alternatives of the applicant is to continue to refer patients to providers in the service area with a 3T MRI. Please discuss why this alternative may not be a practicable alternative.

28. **Section C, Contribution to Orderly Development Item 3 (Staffing)**

Please provide the current and proposed staffing pattern for all employees and compare the staff salaries to the prevailing wage patterns in the service area. Also, please provide the reference for the area wide wages.

Position Title	Current FTEs Existing 3 MRIs	Proposed FTEs for 3T MRI	Net Change	EMC Average Wage	Area-wide Wage Average
Total					

29. **Section C, Contribution to Orderly Development Item 8 and 9**

The applicant has responded N/A to items 8 and 9. Please provide a narrative response addressing the question.

30. **Outstanding Project Update**

A brief two to three sentence update will be appreciated regarding the progress on the implementation of the following projects:

CN1207-034A-Renovation, upgrade and modernization of adult operating rooms and addition of 4 ORs
CN0405-047A – Erlanger East Expansion
CN1012-056A.- Erlanger North Conversion of 30 acute care beds to 30 skilled nursing beds & initiation of skilled nursing services

Please include where the project currently stands (i.e., what phase) in the implementation process, when the projected is expected to be completed and the expiration date of the Certificate of Need

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is November 18, 2014. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ɔ 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please contact this office.

Sincerely,

Phillip M. Earhart
HSD Examiner
PME

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax:615/532-9940

September 29, 2014

Mr. Joseph M. Winick
Senior Vice President -Planning & Business Development
Erlanger Health System
975 East 3rd Street
Chattanooga, Tennessee 37403

RE: Certificate of Need Application CN1409-038
Erlanger Medical Center

Dear Mr. Winick,

This will acknowledge our September 26, receipt of your supplemental response for a Certificate of Need for the addition of a 3.0 T Magnetic Resonance Imaging (MRI) scanner at Erlanger Medical Center, 975 East 3rd Street, Chattanooga (Hamilton County), Tennessee.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 p.m., September 30, 2014. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

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1. **Section B Item Project Description II.E 1.b and 1.3**

   It is noted the applicant will purchase the 3T MRI. However, please itemize the $3,013,702 cost for fixed equipment in the Project Costs Chart. This amount is not found in the Equipment Quote found in Attachment A-59.

2. **Section C, Economic Feasibility, Item 1 (Historical & Projected Data Charts)**

   The historical chart indicates the applicant has operated at a loss of approximately $12 million in 2011, $26 million in 2012, and $24 million in 2013. A Projected Data Chart for Erlanger Medical Center for Year One and Year Two of the proposed project was requested in Supplemental One, but not provided. The applicant did provide a copy of the FY2014 audit report which shows positive income from operations of $17,917,993. Please clarify if the applicant intended to submit the audit in lieu of the request for a Projected Data Chart for Erlanger Medical Center. If so, please provide an estimate of the financial performance for Erlanger Medical Center in Year Two (2015) of the proposed project.

3. **Section C. (Economic Feasibility) Question 5**

   The average gross charge, average deduction and average net charge are noted. However, please identify the project's average gross charge, average

deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please verify the following:

Year One
Year One Gross Charge: $3,614.00
Year One Deduction from Revenue: $2,952.00
Average Net Charge: $662.00

Year Two
Year Two Gross Charge: $3,774.00
Year Two Deduction from Revenue: $3,107.00
Average Net Charge: $667.00

4. **Section C. (Economic Feasibility) Question 6.B**

The comparison of the proposed MRI Gross Charges per Procedure/Treatment by quartiles using the following table is noted. However, please compare the average gross charge of $3,614.00 in Year One to the charges below.

Gross Charges per Procedure/Treatment
By Quartiles
YEAR = 2013

Equipment Type	1st Quartile	Median	3rd Quartile
MRI	$1,570.39	$2,175.15	$3,498.94
Source: Medical Equipment Registry – 8/11/2014			

5. **Section C, Economic Feasibility, Item 9**

As requested in Supplemental One, please indicate how medically indigent patients will be served by the project.

6. **Section C, Contribution to Orderly Development Item 3 (Staffing)**

The table of the current and proposed staffing patterns in the proposed service area is noted. However, please provide the reference for the area wide wages, i.e.- Tennessee Department of Labor and Workforce Development and/or other documented sources.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is November 18, 2014. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

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Should you have any questions or require additional information, please contact this office.

Sincerely,

Phillip M. Earhart
HSD Examiner
PME